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PREFACE

This document has been prepared for the use of the Committee on Ways and Means by its staff with the assistance of the Congressional Research Service.

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I. MEDICARE

Medicare, authorized under title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance (part A) program and the supplementary medical insurance (part B) program.

ELIGIBILITY

Most Americans age 65 or older are automatically entitled to protection under part A. Persons age 65 or older who are not "fully insured" (i.e., not eligible for monthly social security or railroad retirement cash benefits) may obtain coverage, providing they pay the full actuarial cost of such coverage. The monthly premium, as of January 1, 1985, is $174. Also eligible, after a 2-year waiting period, are people under age 65 who are receiving monthly social security benefits on the basis of disability and disabled railroad retirement system annuitants. (Dependents of the disabled are not eligible.) Most people who need a kidney transplant or renal dialysis because of chronic kidney disease are, under certain circumstances, entitled to benefits under part A regardless of age.

Part B of Medicare is voluntary. All persons age 65 or older (whether "insured" or not) may elect to enroll in the supplementary medical insurance program by paying the monthly premium. Persons eligible for part A by virtue of disability or chronic kidney disease may also elect to enroll in part B. The premium, as of January 1, 1985, is $15.50.

NUMBER OF BENEFICIARIES

In fiscal year 1985, approximately 27.3 million aged and 3.0 million disabled will have protection under part A. Of those, it is estimated that 7.1 million aged and 0.8 million disabled will actually receive reimbursed services. In fiscal year 1985, 27.2 million aged and 2.7 million disabled will be enrolled in part B. Over 19.7 million of the aged and 1.9 million of the disabled will receive part B reimbursed services.

TABLE 1.—NUMBER OF AGED AND DISABLED ELIGIBLE ENROLLEES AND BENEFICIARIES AND AVERAGE AND TOTAL MEDICARE BENEFIT PAYMENTS

[Persons in thousands]

	1980 (actual)	1984 (actual)	1985 [1] (estimate)	1986 [1] (estimate)	Projected average annual growth 1980–86
Part A:					
Persons with hospital insurance protection (monthly average):					
Aged	24,471	26,722	27,314	27,924	2.2
Disabled	2,977	2,879	2,961	2,946	—.2
Beneficiaries receiving reimbursed services:					
Aged	5,860	6,850	7,090	7,340	3.8
Disabled	800	770	790	790	—.2
Average annual benefit per person enrolled: [2]					
Aged	$854	$1,375	$1,556	$1,600	11.0
Disabled	$970	$1,643	$1,834	$1,905	11.9
Total benefit payments per beneficiary reimbursed:					
Aged	$3,568	$5,362	$5,993	$6,087	9.3
Disabled	$3,609	$6,143	$6,873	$7,105	12.0
Part B:					
Beneficiaries:					
Persons enrolled (average):					
Aged	24,410	26,583	27,189	27,819	2.2
Disabled	2,703	2,661	2,680	2,697	—.3
Beneficiaries receiving reimbursed services:					
Aged	15,525	19,060	19,719	20,412	4.7
Disabled	1,737	1,885	1,926	1,961	2.0
Average annual benefit per person enrolled:					
Aged	$346	$623	$692	$768	14.2
Disabled	$630	$1,094	$1,228	$1,358	13.6
Total benefit payments per beneficiary reimbursed:					
Aged	$544	$869	$954	$1,047	11.5
Disabled	$980	$1,545	$1,709	$1,868	11.4

[1] Represents current policy (e.g., no payment freeze in DRG rates).

[2] Does not include administrative cost.

Source: Health Care Financing Administration.

COVERAGE

Most individuals establish entitlement to part A on the basis of work in employment covered by either the Social Security or railroad retirement systems. Certain employment is excluded from Social Security (including part A hospital insurance) taxation.

The Tax Equity and Fiscal Responsibility Act of 1982 extended the hospital insurance tax to Federal employment effective with respect to wages paid on or after January 1, 1983. For calendar year 1984, the tax was 1.3 percent of wages up to $37,800 and, for calendar year 1985, it is 1.35 percent of wages up to $39,600. Beginning January 1, 1983, Federal employment is used to determine eligibility for protection under Medicare part A. A transitional provision allows individuals who are in the employ of the Federal Government both before and during January 1, 1983 to have their prior Federal employment considered as employment for purposes of providing Medicare coverage.

BENEFITS

Part A of Medicare will pay for:

1. *Inpatient hospital care.*—All reasonable expenses for the first 60 days minus a deductible ($400 in calendar year 1985) in each benefit period. For days 61–90, a coinsurance amount ($100 in calendar year 1985) is deducted. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60 day lifetime reserve. A coinsurance amount ($200 in calendar year 1985) is also deducted for each reserve day.

2. *Skilled nursing facility care.*—Up to 100 days (following hospitalization) in a skilled nursing facility for persons in need of continued skilled nursing care and/or skilled rehabilitation services on a daily basis. After the first 20 days, there is a daily coinsurance amount deducted ($50 in calendar year 1985).

3. *Home health care.*—An unlimited number of medically necessary home health visits by nurses, therapists, and other health workers for a homebound individual.

4. *Hospice care.*—For the period November 1, 1983 to October 1, 1986, Medicare coverage for hospice care services provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less.

Part B of Medicare pays 80 percent of the reasonable charges (or of reasonable cost) for covered services in excess of an annual deductible ($75). Services covered include the following:

1. *Doctor's services.*—Including surgery, consultation, and home, office and institutional visits. Certain limitations apply for services rendered by dentists, podiatrists and chiropractors and for the treatment of mental illness.

2. *Other medical and health services.*—Laboratory and other diagnostic tests, X-ray and other radiation therapy, outpatient services at a hospital, rural health clinic services, home dialysis supplies and equipment, artificial devices (other than dental), physical and speech therapy, and ambulance services.

3. Home health services.—Unlimited number of medically necessary home health visits. The 20 percent coinsurance and $75 deductible do not apply for such benefits.

Table 3 illustrates the deductible, coinsurance and premium amounts for both part A and part B services from the inception of Medicare.

TABLE 2.—BENEFIT PAYMENTS BY SERVICE UNDER PART A AND PART B, FISCAL YEARS 1976, 1981, AND 1986

[Dollars in millions]

	1976 payments (actual)		1981 payments (actual)		1986 payments [1] (estimate)		Projected average annual growth (1976–86)
	Amount	Percent	Amount	Percent	Amount	Percent	
Part A							
For inpatient hospital services	$11,742	69.3	$27,757	67.3	$47,155	62.6	14.9
For skilled nursing facility services	308	1.8	424	1.0	658	.9	7.9
For home health services	217	1.3	726	1.8	2,447	3.2	27.4
For hospice services	0	0	0	0	30	0	....
Total benefit payments	12,267	72.4	28,907	70.1	50,290	66.8	15.2
Part B							
For physician services	3,439	20.3	8,859	21.5	17,701	23.5	17.8
For radiology and pathology services	251	1.5	654	1.6	664	.9	10.2
For outpatient services	717	4.2	2,215	5.4	5,266	7.0	22.1
For other medical and health services	265	1.6	617	1.5	1,410	1.9	18.2
Total benefit payments	4,672	27.6	12,345	29.9	25,041	33.2	18.3
Total	16,939	100.0	41,252	100.0	75,331	100.0	16.1

[1] Represents current policy (e.g., no payment freeze in DRG rates).

Source: Health Financing Administration.

TABLE 3.—HISTORICAL AND PROJECTED AMOUNTS OF PART A (HOSPITAL INSURANCE) AND PART B (SMI) DEDUCTIBLE, COINSURANCE AND PREMIUMS [1]

For benefit periods begining in	Inpatient hospital [2]			Skilled nursing facility 21st thru 100th day coinsurance per day [5]	HI monthy premium [6]		SMI deductible	SMI premium	
	First 60 days deductible	61st thru 90th day coinsurance per day [3]	60 lifetime reserve days (nonrenewable) coinsurance per day [4]		Effective date	Amount		Effective date	Amount
1966	$40	$10	(7)	(7)			$50	7/66	$3.00
1967	40	10	(7)	$5.00			50		3.00
1968	40	10	$20	5.00			50	4/68	4.00
1969	44	11	22	5.50			50		4.00
1970	52	13	26	6.50			50	7/70	5.30
1971	60	15	30	7.50			50	7/71	5.60
1972	68	17	34	8.50			50	7/72	5.80
1973	72	18	36	9.00	7/73	$33	60	[8] 9/73	6.30
1974	84	21	42	10.50	7/74	36	60	7/74	6.70
1975	92	23	46	11.50	7/75	40	60		6.70
1976	104	26	52	13.00	7/76	45	60	7/76	7.20
1977	124	31	62	15.50	7/77	54	60	7/77	7.70
1978	144	36	72	18.00	7/78	63	60	7/78	8.20
1979	160	40	80	20.00	7/79	69	60	7/79	8.70
1980	180	45	90	22.50	7/80	78	60	7/80	9.60
1981	204	51	102	25.50	7/81	89	60	7/81	11.00
1982	260	65	130	32.50	7/82	113	75	7/82	12.20
1983	304	76	152	38.00		113	75		12.20
1984	356	89	178	44.50	1/84	155	75	1/84	14.60

TABLE 3.—HISTORICAL AND PROJECTED AMOUNTS OF PART A (HOSPITAL INSURANCE) AND PART B (SMI) DEDUCTIBLE, COINSURANCE AND PREMIUMS [1]—Continued

For benefit periods begining in	Inpatient hospital [2]			Skilled nursing facility 21st thru 100th day coinsurance per day [5]	HI monthy premium [6]		SMI deductible	SMI premium	
	First 60 days deductible	61st thru 90th day coinsurance per day [3]	60 lifetime reserve days (nonrenewable) coinsurance per day [4]		Effective date	Amount		Effective date	Amount
1985	400	100	200	50.00	1/85	174	75	1/85	15.50
1986 [9]	476	119	238	59.50	1/86	205	75	1/86	17.30
1987 [9]	524	131	262	65.50	1/87	228	75	1/87	19.30

[1] For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services were furnished. For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.

[2] For care in psychiatric hospital—190 day lifetime limit.

[3] Always equal to ¼ of inpatient hospital deductible.

[4] Always equal to ½ of inpatient hospital deductible.

[5] Always equal to ⅛ of inpatient hospital deductible.

[6] Not applicable prior to July 1973. Applies to individuals who are not fully insured.

[7] Not covered.

[8] For August 1973 the premium was $6.10.

[9] Administration projections under current law.

Note: In addition to the deductible and coinsurance amounts shown in the table, the first 3 pints of blood are not reimbursed by Medicare. Currently there is no deductible or coinsurance on home health benefits. From January 1973 to June 30, 1982, there was a $60 annual deductible and prior to July 1, 1981, benefits were limited to 100 visits per benefit period under part A and 100 visits per calendar year under part B. Special limits apply to certain benefits: (1) Outpatient physician services for mental illness: 50 percent of approved charges; up to a maximum of $250 in benefits per year; (2) Physical therapy services furnished by physical therapists in independent practice: Maximum annual approved charges July 1, 1973, through December 31, 1981, $80 per year; January 1, 1982 and therafter, $400 per year.

Source: Health Care Financing Administration.

ADMINISTRATION

Responsibility for administration of the Medicare program has been delegated by the Secretary of Health and Human Services to the Administrator of the Health Care Financing Administration (HCFA). Much of the day-to-day operational work of the program is performed by "intermediaries" and "carriers" which have responsibility for reviewing claims for benefits and making payments.

In general, hospitals and other providers paid under part A of Medicare can nominate, subject to HCFA's approval, a national, State, or other public or private agency to serve as a fiscal intermediary between themselves and the Federal Government.

Medicare payments that are based on costs that are necessary to meet the costs which must be incurred by an efficiently and economically operated organization are made by insurance organizations, referred to as carriers, that have been selected by the Secretary to serve specified geographical areas.

Medicare administrative costs amount to 2.5 percent of program outlays.

Hospitals

The Social Security Amendments of 1983 (Public Law 98–21) altered the way in which Medicare pays hospitals. From the inception of the program, Medicare had paid hospitals on a "reasonable cost" basis. Effective October 1, 1983, Medicare began paying under a prospective payment system. Medicare payments for inpatient operating costs of hospitals are determined in advance and made on a per discharge basis. A fixed amount per case is paid based upon the type of case or "diagnosis-related group" (DRG) into which the case is classified.

The payment system is not applied to capital-related costs nor to direct medical education costs. These expenses will continue to be reimbursed on a reasonable cost basis. Capital costs will no longer be excluded from the system beginning October 1, 1986. Certain hospitals excluded from the system are: psychiatric, long-term care, children's and rehabilitation hospitals. Excluded hospitals will continue to be paid based on reasonable costs subject to certain rate of increase limitations.

Additional payments may be made for extraordinarily costly cases and for the indirect costs of medical education. An adjustment will be made for the wage level in the area in which the hospital is located. In addition, there are certain other exceptions and adjustments including those for sole community providers, national and regional referral centers, cancer treatment centers and hospitals that serve a disproportionately large number of low income and Medicare beneficiaries.

The payment system will be phased in over 3 years from payments based on an individual hospital's historic costs to payments based on the new prospective payment rates. In addition, the system will be phased in from payments representing nine regional payment levels to one national payment level for each DRG. There will be separate payment levels for urban and rural areas.

Hospitals and other institutional providers receiving payment under Medicare part A submit bills on behalf of the beneficiary and agree to accept the program's payment as payment in full. In general, providers are permitted to charge beneficiaries only the deductible and coinsurance amounts authorized by law.

Physicians

Medicare law provides that payments are to be made to or on behalf of persons enrolled under part B of the Medicare program for expenses incurred by them for covered physicians' services and for covered services provided by other noninstitutional providers. After certain deductible and coinsurance amounts have been met, Medicare pays for covered physician services on the basis of "reasonable charges".

The reasonable charge for a specific service, in the absence of unusual medical complications, can be: (1) no higher than the individual practitioner's *customary charge for that service;* (2) no higher than the applicable *prevailing charge* for similar services in the locality; and (3) no higher than the *actual charge* of the individual physician rendering the service.

Customary and prevailing charge screens used to calculate the reasonable charge (approved charges) are usually updated every July 1. The Deficit Reduction Act of 1984 (Public Law 98-369) freezes the amount Medicare reimburses for physician services for the 15-month period beginning July 1, 1984, through September 30, 1985. Therefore, the annual increases in customary and prevailing charges otherwise slated for July 1, 1984, did not occur. In addition, the legislation provided that physicians would not be allowed to increase their actual charges to beneficiaries during this 15-month freeze period, unless the physician was a participating physician under the Medicare program.

The following table shows the number of participating institutions and organizations.

TABLE 4.—PARTICIPATING INSTITUTIONS AND ORGANIZATIONS (JUNE 1984)

Hospitals	6,675
Short stay	6,038
Long stay	637
Skilled nursing facilities	5,952
Home health agencies	4,684
Independent laboratories	3,801
Outpatient physical therapy providers	791
Portable X-ray suppliers	269
Rural health clinics	420
Comprehensive outpatient rehabilitation facilities	48
Ambulatory surgical centers	155
Hospices	108
Facilities providing services to renal disease beneficiaries	1,335
Hospitals certified as both renal transplant and renal dialysis centers	147
Hospitals certified as renal transplant centers	16
Hospital dialysis facilities	117
Non-hospital renal dialysis facilities	645

TABLE 4.—PARTICIPATING INSTITUTIONS AND ORGANIZATIONS (JUNE 1984)—Continued

Dialysis centers only	359
Inpatient care	51

HOSPITAL AND SKILLED NURSING FACILITY BEDS (JUNE 1984)

Hospitals	1,144,142
Short stay	1,023,465
Long stay	120,677
Skilled nursing facilities	530,403

Source: Health Care Financing Administration.

END STAGE RENAL DISEASE PROGRAM

In 1972, Public Law 92-603 was signed extending Medicare coverage for certain individuals with chronic renal failure. The Medicare program covers individuals, under age 65, who suffer from end stage renal disease, if they are (1) fully insured for old age and survivor insurance benefits, or (2) are entitled to either monthly social security benefits, or (3) are spouses or dependents of individuals described in (2). Such persons must be medically determined to be suffering from end stage renal disease and must file an application for benefits. Approximately 7 percent of the population suffering from end stage renal disease (ESRD) does not meet any of these requirements and thus are not covered for Medicare renal benefits.

Benefits for qualified end stage renal disease beneficiaries include all part A (hospital insurance) and part B (supplementary medical insurance) medical items and services. ESRD beneficiaries are automatically enrolled in the part B portion of Medicare and must pay the monthly premium for such protection.

Table 5 shows program expenditures, number of beneficiaries, and the average expenditure per person from 1974 to projected expenditures and beneficiaries through 1990. Total projected program expenditures for Medicare end stage renal disease program for fiscal year 1986 amount to $2.6 billion. In fiscal year 1986, there are projected to be 96,100 ESRD beneficiaries including successful transplant patients.

TABLE 5.—ESRD MEDICARE BENEFICIARIES AND PROGRAM EXPENDITURES

[Dollars in millions]

Year	Expenditures	Beneficiaries	Per person
1974	$229	15,993	$14,300
1975	361	22,674	15,900
1976	512	28,941	17,700
1977	641	35,889	17,900
1978	800	43,482	18,400
1979	1,010	52,636	19,200
1980	1,250	60,814	20,600

TABLE 5.—ESRD MEDICARE BENEFICIARIES AND PROGRAM EXPENDITURES—Continued

[Dollars in millions]

Year	Expenditures	Beneficiaries	Per person
1981	1,472	68,288	21,500
1982	1,650	75,097	22,000
1983	1,889	81,873	23,100
1984	2,100	87,000	24,200
1985	2,300	92,000	25,400
1986	2,600	96,100	26,700
1987	2,800	99,700	28,000
1988	3,000	102,600	29,500
1989	3,200	104,800	30,900
1990	3,500	106,400	32,500

Note: Projections for 1985–90 are subject to revision by the Office of Financial and Actuarial Analysis.

Source: Office of Research, Health Care Financing Administration, Department of Health and Human Services.

Outpatient maintenance dialysis can be provided in either a hospital-based setting or independent (often called freestanding) setting.

Until 1983, payment for maintenance dialysis under Medicare had been based on cost-based principles in the case of outpatient dialysis care furnished by hospitals and on the basis of "reasonable" or allowed charges in the case of services provided by independent (or freestanding) dialysis treatment facilities.

In 1981, the Congress passed Public Law 97–35 which required the Secretary to establish dual, or separately calculated, prospective rates for hospital-based and for freestanding facilities. Congress expressed a preference that these formulas be composite in nature, that is, they take into account the proportions of hospital-based and independent facility patients dialyzing at home and the relative costs of providing dialysis at home and in the facility setting.

Under the regulations implementing the law, before any exceptions are taken into account, the average (base) payment rate under the prospective payment system is $127 per treatment for independent facilities and $131 per treatment for hospital units, regardless of whether the treatment is furnished in the facility or in the patient's home. The payment rates are adjusted by an area wage index to take into account differences in the local labor costs of dialysis facilities so that the actual payment rates (without any adjustments for exceptions) may vary above and below the average payment rates established for hospital-based and independent dialysis units. The new prospective payment system was implemented as of August 1, 1983.

Kidney transplants are covered for Medicare beneficiaries. The cost incurred by the kidney donor are reimbursed by Medicare even if the donor is not a Medicare beneficiary. Medicare reimbursed more than 90 percent of the kidney transplants performed in the United States. Table 6 shows the numbers of transplants performed in Medicare-certified hospitals.

TABLE 6.—TOTAL KIDNEY TRANSPLANTS PERFORMED IN MEDICARE CERTIFIED U.S. HOSPITALS

Calendar year	Total transplants	Living donor		Cadaveric donor	
		Number	Percent	Number	Percent
1979	4,189	1,186	28	3,003	72
1980	4,697	1,275	27	3,422	73
1981	4,883	1,458	30	3,425	70
1982	5,358	1,677	31	3,681	69
1983	6,112	1,784	29	4,328	71

HOME HEALTH

The hospital insurance (part A) and the supplementary medical insurance (part B) programs cover home health services without a deductible or coinsurance charge. There is no limitation on the number of home health visits covered under the home health program, and there is no prior hospitalization requirement. When an individual is covered under part A and B of the Medicare program, the individual will generally receive payment for home health services under part A of the program.

Reimbursement to home health agencies is based on Medicare rules for reasonable cost reimbursement. However, home health agencies are required to use the cost per visit by type of service for apportioning costs. Under this method, the total allowable costs of all visits for each type of service (skilled nursing, home health aide, etc.) is divided by the total number of visits by type of service. These average cost per visit amounts are multiplied by the number of covered Medicare visits for each type of service. The products represent the cost Medicare will recognize by type of service, subject to home health agency cost limits.

Cost limits for home health agencies are set at the 75th percentile of average per visit costs. Though the limits are established by type of service, they are applied to each agency as a single aggregate limit based on the number of visits for each type of service.

Public Law 97-248 required the Secretary to establish a single reimbursement limit for home health agencies based on the cost experience of freestanding home health agencies. In establishing the single limits, the Secretary was required to make adjustments, as appropriate, for hospital-based home health agencies based on legitimate cost differences resulting from such factors as a more complex case mix and the effects of Medicare cost allocation requirements. The single limits were published July 2, 1984. An "add on" for hospital based facilities was provided.

The Medicare home health benefit is the fastest growing part of the Medicare program. Table 7 below indicates the increase in Medicare program expenditures for home health care.

TABLE 7.—MEDICARE HOME HEALTH SERVICES

Calendar year	Total Medicare reimbursements (millions)	Percent change	Total Medicare visits (millions)	Visits per 1,000 enrollees	Visits per user	Average charge per visit
1969	$81		8.5	424		$10
1970	63	−22.7	6.0	291		12
1971	57	−8.8	4.8	226		13
1972	66	15.7	5.2	241		14
1973	93	40.9	6.4	265		15
1974	139	48.6	7.9	340	20.6	17
1975	215	55.1	10.8	431	21.6	20
1976	297	38.1	13.6	520	22.7	22
1977	371	24.9	15.8	597	22.5	25
1978	443	19.5	17.6	639	22.5	27
1979	541	22.4	19.9	717	22.9	30
1980	662	22.8	22.6	792	23.4	33
1981	859	29.1	26.2	902	24.3	36
1982	1,120	30.3	31.3	1,060	26.3	40
1983[1]	1,413	26.2	37.3	1,233	28.3	43
1985[1]	2,159					
1989[1]	3,190	[2] 10.3				

[1] Projections based on fiscal years.

[2] Average projected annual growth from 1984 to 1989.

Source: HCFA/Bureau of Data Management and Statistics.

HOSPICE CARE

Public Law 97-248 authorizes Medicare part A coverage for hospice care services provided to individuals who are entitled to Medicare part A benefits and who are certified to be terminally ill.

On December 16, 1983, the Health Care Financing Administration (HCFA), published regulations to implement the hospice provisions of Public Law 97-248. Among other things, the regulations establish requirements for eligibility, covered benefits, services, reimbursement procedures, and the conditions a hospice must meet to be approved for participation in the Medicare program.

Part A beneficiaries may elect to receive hospice care in lieu of most other Medicare benefits for up to two periods of 90 days each, plus an additional 30 days.

The statute provides that payment to hospice providers be equal to the costs which are reasonable and related to the cost of providing hospice care, or which are based on such other tests of reasonableness as the Secretary may prescribe, subject to a "cap amount." The cap amount for a beneficiary for a year is $6,500, adjusted annually by the Medical component of the CPI.

HCFA has implemented a prospective payment methodology for hospice care. Under this methodology, hospices would be paid one of several predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates would vary according to the level of care furnished to the beneficiary. Total reimbursement to a hospice for care furnished to the Medicare beneficiary would vary by the length of the patient's period in the hospice program as well as by the characteristics of the services (intensity and site) program furnished to the beneficiary.

The regulations established four basic payment categories. The payment rates are national rates which are adjusted by the BLS wage index for an area. The published payment rates were:

(a) *Routine home care day.*—Routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate would be paid for every day a patient is at home and under the care of the hospice regardless of the volume or intensity of the services provided on any given day as long as less than 8 hours of care are provided. Under the regulations the national rate for a home care day is $46.25. Public Law 98-617 increased the national rate to $53.17.

(b) *Continuous home care day.*—A continuous home care day is day on which an individual who has elected to receive hospice care receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is furnished only during brief periods of crisis and only as necessary to maintain the terminally ill patient at home. Home care would have to be provided for a period of at least 8 hours before it would be considered to fall within the category of continuous home care. The national payment amount is $358.67 for twenty-four hour care.

(c) *Inpatient respite care day.*—An inpatient respite care day is one on which the individual who has elected hospice care receives care in an approved facility on a short-term (not more than 5 days at a time) basis for the respite of his caretakers. The national payment rate is $55.33.

(d) *General inpatient care day.*—A general inpatient care day is one on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. Care may be provided in a hospital, skilled nursing facility or inpatient unit of a freestanding hospice. The national payment rate is $271.00.

SKILLED NURSING FACILITY

In general, skilled nursing facilities are reimbursed on the basis of reasonable costs subject to certain limits.

Reimbursement limits for skilled nursing facilities have been established for inpatient general routine service costs. Limits are set at 112 percent of the average labor-related and average non-labor related costs of each comparison group.

The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) required the Secretary to establish a single payment limit for both freestanding and hospital-based skilled nursing facilities (SNF's) based on the cost experience of freestanding facilities, subject to adjustments for hospital-based SNF's deemed appropriate. The provision was to be effective October 1, 1982. The Social Security Amendments of 1983 (Public Law 98-21) postponed the effective date for 1 year. This provision was further modified in Public Law 98-369 (the Deficit Reduction Act of 1984). The law provides that for cost reporting periods beginning on or after October 1, 1982, and prior to July 1, 1984, hospital-based facilities and freestanding facilities would be reimbursed on the same basis used to calculate reimbursement limits that have been in effect prior to the passage of the Tax Equity and Fiscal Responsibility Act (i.e., going back to prior law). For cost reporting periods beginning on or after July 1, 1984, separate limits would continue to be established for freestanding facilities in urban and rural areas at 112 percent of the mean operating costs of urban and rural freestanding facilities, respectively. Limits for urban or rural hospital-based facilities would be set at the appropriate freestanding facility limit plus 50 percent of the difference between the freestanding facility limit and 112 percent of the mean operating costs of hospital-based facilities. Adjustments to take account of administrative costs for hospital based facilities would be allowed as an add on. As of publication, none of the above provisions have yet been implemented. In addition, Public Law 98-21 required the Secretary to report by December 31, 1983 on the effect of the implementation of the TEFRA single-rate provision on hospital-based SNF's, given the difference (if any) in the patient populations served by such facilities and by freestanding SNF's. Further, the Secretary was required to report by the end of 1983 on the impact of hospital prospective payment on SNF's. As of January 1, 1984, the report had not been issued.

Public Law 97-248 also required the Secretary to develop, in consultation with the Senate Finance Committee and the House Committee on Ways and Means, proposals for the prospective reimbursement of SNF's. The Secretary was required to report on these proposals to Congress by December 31, 1982. Public Law 98-21 further delayed the deadline for the report to December 1983. The report was not sent. Public Law 98-369 further delayed the requirement. The Secretary was required to submit to Congress by August 1, 1984, the results of the study required in TEFRA. In addition the Secretary was required to report to Congress by December 1, 1984, on the range of options available for prospective payment of skilled nursing facilities. As of publication, none of the required reports have been received by Congress.

UTILIZATION AND QUALITY CONTROL PEER REVIEW PROGRAM

The Social Security Amendments of 1972 provided for the establishment of Professional Standards Review Organizations (PSRO's) throughout the country which were charged with the comprehensive and on-going review of services provided under Medicare, Medicaid, and the maternal and child health programs. PSRO's determined, for purposes of reimbursement under these programs, whether services are: (1) Medically necessary, (2) provided in accordance with professional standards, and (3) in the case of institutional services, rendered in the appropriate setting.

The Tax Equity and Fiscal Responsibility Act of 1982 repealed the existing PSRO program and established a new program. Under this new program, a Peer Review Organization (PRO) is defined as an entity which is either composed of a substantial number of the licensed doctors of Medicine and osteopathy practicing in the area or has available to it sufficient numbers of such physicians so that adequate peer review of various Medical services can be assured.

The PRO program is similar to the PSRO program with the following important distinctions. Under the new program, eligible organizations may be either for-profit or non-profit and may be either physician groups or have available to them sufficient physicians to perform review. The Secretary is required to consolidate existing PSRO geographic areas. Each State has been designated as a single area, plus the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa (54 PRO's). The Secretary is required to enter into a contract with a peer review organization for each geographic area. Priority consideration must be given to physician-sponsored organizations; payor organizations were excluded from participation until October 1, 1984. Contracts with provider or provider-affiliated organizations are prohibited though subcontracts with such entities are permitted. As of January 1, 1985, the Secretary had entered into agreements with 53 physician-sponsored organizations and one fiscal intermediary. The law provides that contracts are for an initial period of 2 years, renewable biennially. Contracts with PRO's must specify objectives to be achieved for each PRO over the contract period. Performance will be rated in terms of meeting these goals.

These entities may review, subject to the provisions of the contracts, the professional activities of physicians, other practitioners and institutional and noninstitutional providers in rendering services to Medicare beneficiaries. The review is to focus on the necessity and reasonableness of care, quality of care, and the appropriateness of the setting. The determinations of the peer review organizations would ordinarily be binding for purposes of determining whether benefits should be paid.

States are authorized to contract with review organizations for Medicaid review and 75 percent Federal matching is authorized for such purpose.

Hospitals were required to sign an agreement with a PRO in the area on or before November 15, 1984, as a condition of receiving payment under the Medicare program.

FINANCING

Background

The Medicare part A Hospital Insurance Trust Fund (HI) finances inpatient hospital, skilled nursing facility, home health and other institutional services. The part B Supplementary Medical Insurance Trust Fund (SMI) finances principally physician and hospital outpatient services.

The Hospital Insurance Trust Fund is financed primarily through Social Security payroll tax contributions paid by employers, employees and the self-employed. The payroll tax rate for calendar year 1984 was 1.3 percent of earnings up to $37,800 per employee and for 1985 is 1.35 percent of $39,600 per employee. An equal contribution rate is paid by the employer. Table 8 shows the contribution rates and maximum taxable earnings for both HI and the old-age, survivors and disability insurance (OASDI) programs.

TABLE 8.—CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR EMPLOYERS AND EMPLOYEES EACH AND TAXABLE EARNINGS BASES

Calendar year	Employee and employer rates, each (percent)			Taxable earnings base	Maximum HI tax
	OASDI combined	HI	OASDHI combined		
1977	4.95	0.90	5.85	$16,500	$148.50
1978	5.05	1.10	6.05	17,700	194.70
1979	5.08	1.05	6.13	22,900	240.45
1980	5.08	1.05	6.13	25,900	271.95
1981	5.35	1.30	6.65	29,700	386.10
1982	5.40	1.30	6.70	32,400	421.20
1983	5.40	1.30	6.70	35,700	464.10
1984	5.70	1.30	7.00	37,800	491.40
1985	5.70	1.35	7.05	39,600	534.60
1986	5.70	1.45	7.15	(1)	(1)
1987	5.70	1.45	7.15	(1)	(1)
1988	6.06	1.45	7.51	(1)	(1)
1989	6.06	1.45	7.51	(1)	(1)
1990	6.20	1.45	7.65	(1)	(1)

[1] The maximum earnings subject to the tax increases each year in accordance with the increase in average earnings.

Those who are uninsured under part A may elect to enroll by paying the full cost of coverage. The cost of the monthly premium for calendar year 1985 is $174.

Part B, which is voluntary, is financed from premiums paid by the aged, disabled and chronic renal disease enrollees and from the general revenues. The premium rate is derived annually based upon the projected costs of the program for the coming year. Under prior law, the premium rate was changed on July 1 of each year. The Social Security Amendments of 1983 (Public Law 98-21) moved the premium increase date to January 1 of each year to coincide with the changed date for the annual Social Security cash benefit cost-of-living (COLA) increase.

Ordinarily, the premium rate is the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the COLA provisions of the Social Security program. Premium income, which originally financed half of the costs of part B, had declined—as a result of this formula—to less than 25 percent of total program income.

The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), temporarily suspended the COLA limitation for 2 years—calendar years 1984 and 1985. During this period, enrollee premiums will be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. The Deficit Reduction Act of 1984 (Public Law 98-369) extended the TEFRA provision through calendar years 1986 and 1987. The premium beginning January 1, 1985, is $15.50 per month.

As noted above, the premiums paid by part B enrollees finance only one-quarter of the cost of the program. The remaining cost is financed from the Federal general revenues.

FINANCIAL STATUS OF THE TRUST FUNDS

The Hospital Insurance Trust Fund balances are dependent upon the income to the HI trust fund primarily through payroll taxes exceeding the outlays for Medicare benefits and administrative costs. Outlays are affected by increases in inpatient hospital expenditures which have been rising at a faster rate than the income to the HI trust fund. Table 9 shows the percentage increase in Medicare outlays from fiscal year 1967 to fiscal year 1984 and the CBO projections from 1985 to 1990. According to the Congressional Budget Office, hospital costs attributable to Medicare beneficiaries are projected to increase over the 1985-90 period at an average annual rate of 10.1 percent, while income is projected to grow at an annual rate of 7.6 percent.

Due to this excess of outlays over income, the HI trust fund faces serious financial difficulties in the future. Under current policies, the trust fund is expected to be depleted in the early to middle part of the next decade.

TABLE 9.—MEDICARE OUTLAYS, FISCAL YEARS 1967-90

Fiscal year	Part A		Part B		Total	
	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)
1967	2,597	....	799	....	3,396	....
1968	3,815	46.9	1,532	91.7	5,347	57.4
1969	4,758	24.7	1,840	20.1	6,598	23.4
1970	4,953	4.1	2,196	19.3	7,149	8.4
1971	5,592	12.9	2,283	4.0	7,875	10.2
1972	6,276	12.2	2,544	11.4	8,820	12.0
1973	6,842	9.0	2,637	3.7	9,479	7.5
1974	8,065	17.9	3,283	24.5	11,348	19.7
1975	10,612	31.6	4,170	27.0	14,782	30.3
1976[1]	12,579	18.5	5,200	24.7	17,779	20.3
1977	15,207	20.9	6,342	22.0	21,549	21.2
1978	17,862	17.5	7,350	15.9	25,211	17.0

TABLE 9.—MEDICARE OUTLAYS, FISCAL YEARS 1967–90—Continued

Fiscal year	Part A		Part B		Total	
	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)	Dollars (in millions)	Percent increase (over prior year)
1979	20,343	13.9	8,805	19.8	29,148	15.6
1980	24,287	19.4	10,746	22.1	35,034	20.2
1981	29,248	20.4	13,240	23.2	42,488	21.3
1982	34,864	19.2	15,559	17.5	50,423	18.7
1983	38,551	10.6	18,317	17.7	56,868	12.8
1984	42,295	9.7	20,374	11.2	62,669	10.2
1985 (est.)	47,931	13.3	22,433	10.1	70,364	12.3
1986 (est.)	51,485	7.4	25,760	14.8	77,245	9.8
1987 (est.)	56,912	10.5	29,268	13.6	86,180	11.6
1988 (est.)	62,967	10.6	33,532	14.6	96,499	12.0
1989 (est.)	69,799	10.9	38,205	13.9	108,004	11.9
1990 (est.)	77,376	10.9	43,453	13.7	120,829	11.9

[1] In the transition quarter from July to October 1976 (when the beginning of the Federal fiscal year was changed), outlays were $4,805 million. These outlays do not appear in the table.

Source: 1983 Annual Report of the Board of Trustees: Federal Hospital Insurance Trust Fund and Supplementary Medical Insurance Trust Fund and CBO projections for 1985 through 1990 under current law.

Interfund borrowing

The Old-Age and Survivors Trust Fund has borrowed $12.4 billion from the HI trust fund.

The OASI trust fund was first authorized to borrow from the HI trust fund and the Disability Insurance (DI) Trust Fund in Public Law 97–123. The Social Security Amendments of 1983 (Public Law 98–21) extended the interfund borrowing authority from 1982 through 1987.

Under the law, loans would be required to be repaid at the earliest possible date, but not later than 1989. OASDI could not borrow from HI in any month in which the HI trust fund ratio is under 10 percent. In 1983 through 1987, OASDI would repay loans from HI whenever the OASDI fund ratio at the end of the year exceeded 15 percent. In 1988 through 1989, OASDI would repay HI the loan balance outstanding at the end of 1987 plus outstanding interest. On January 31, 1985, the OASI fund repaid $1.8 billion in principal on the loan to the HI fund. The repayment is scheduled to be completed with payments in January of 1986 and 1987.

Supplementary medical insurance

Because the Supplementary Medical Insurance Trust Fund (SMI) is financed through beneficiary premiums and the general revenues, it does not face the prospect of depletion as does the HI trust fund. However, the rapidly rising cost of health care is placing a heavy burden on the SMI trust fund—causing beneficiary premiums to rise and increasing the Federal deficit.

CBO estimates that SMI outlays will increase at an annual rate of 13.5 percent from 1985 through 1990. The share of general revenues necessary to finance the SMI trust fund will rise from 3.6 percent to 5.0 percent between 1985 to 1990. By share of general revenues, it is meant the amount of total revenues less revenues earmarked for certain functions (e.g., payroll taxes).

HI trust fund income, outlays, and balance

Table 10 shows the projections of the Congressional Budget Office under its baseline, low and high growth alternatives and the administration for the HI trust funds with respect to income, outlays and balances for the years 1985 through 1990.

The CBO and administration estimates differ for several important reasons. First, the underlying economic assumptions are different (see Section 5). Second, the administration estimates incorporate into current law the budget proposals which will be implemented by regulation. These include the assumption that prospective payment rates for fiscal year 1986 would be frozen at the level for 1985. Third, CBO incorporates the actual interfund borrowing repayments to HI on January 31, 1985 into trust fund income. The administration numbers reflect these transfers only in the trust fund balance and the 1985 transfer will be $424 million higher than shown. Fourth, the administration assume that DRG rates will be increased after fiscal year 1986 at a rate equal to market basket inflation while CBO assumes market basket plus 0.25 percent.

The projections shown in table 8 for the hospital insurance component of Medicare are particularly uncertain after 1985 because of uncertainties concerning future hospital reimbursements. The Social Security Amendments of 1983 instituted a prospective reimbursement system for inpatient hospital services. For 1984 and 1985, the Social Security Amendments gave guidance concerning the setting of the DRG rates.

During the first two years of the new prospective payment system, the DRG rates were to be budget neutral. The Deficit Reduction Act of 1984 established a maximum cap on the rate of increase of DRG rates in 1986. After 1986, the DRG rates are to be set by the Secretary of Health and Human Services, advised by an independent commission. For 1987–1990 the CBO baseline assumes that DRG rates will grow by 0.25 percentage points more than the increase in the cost of a market basket of goods and services typically purchased by hospitals. In addition, hospital insurance outlays also rise with projected increases in eligible beneficiaries and hospital utilization.

Under the baseline projections, from 1985 to 1990, outlays increase at an annual rate of 10.1 percent while income increases at an annual rate of 7.6 percent. This leaves a projected balance in the HI trust fund at the end of 1990 of $50.2 billion.

Under the low growth projections, outlays increase at an annual rate of 8.4 percent while income grows at an annual rate of 5.0 percent from 1985 to 1990. This difference of 3.4 percent between outlays and income compared to the baseline difference of 2.5 percent, causes the balance at the end of fiscal year 1990 to be lower: $38.3 billion compared to the baseline balance of $50.2 billion.

Under the high growth projections outlays increase at an annual rate of 12.2 percent compared to income growth of 10.2 percent per year. This leaves a balance of $56.7 billion at the end of fiscal year 1990. The perceived financial status of the HI trust fund in the future is dependent upon the estimated outlay growth compared to revenue growth. A small difference in the assumptions underlying those projections can create large differences in when the HI trust fund will be depleted and upon the amounts needed to keep the trust fund balances positive through a given time period.

TABLE 10.—PROJECTIONS FOR THE HOSPITAL INSURANCE TRUST FUND, BUDGET AUTHORITY, AND OUTLAYS, FISCAL YEARS, UNDER CBO BASELINE, LOW AND HIGH GROWTH SET OF ECONOMIC ASSUMPTIONS AND ADMINISTRATION ASSUMPTIONS, PRESENT LAW

[In billions]

	1985	1986	1987	1988	1989	1990
CBO baseline:						
Total outlays	47.9	51.5	56.9	63.0	69.8	77.4
Income [1]	53.1	62.5	68.4	67.3	71.6	76.7
Year-end-balance	22.3	33.3	44.8	49.2	51.0	50.2
Start of year balance, as percent of outlays	35.9	43.4	58.6	71.2	70.4	65.8
CBO low growth:						
Total outlays	47.9	51.4	56.5	61.3	66.3	71.8
Income [1]	52.9	62.2	66.7	62.3	64.7	67.5
Year-end-balance	22.1	32.9	43.1	44.1	42.5	38.3
Start of year balance, as percent of outlays	35.9	42.9	58.2	70.3	66.5	59.2
CBO high growth:						
Total outlays	47.9	51.6	57.5	64.7	73.6	85.0
Income [1]	53.1	63.1	70.0	70.4	77.1	86.2
Year-end-balance	22.3	33.7	46.2	51.9	55.4	56.7
Start of year balance, as percent of outlays	35.9	43.2	58.7	71.5	70.6	65.3
Administration:						
Total outlays	48.9	49.4	53.3	58.9	65.0	71.6
Income [1]	51.3	57.5	63.5	69.7	75.2	81.1
Year-end-balance	21.0	33.8	50.3	61.1	71.2	80.7
Start of year balance, as percent of outlays	35	42	64	85	94	99

[1] Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers. In addition, it also reflects the interfund borrowing repayments from OASI to HI—$1,824 million in 1985, $4,800 million in 1986, and $5,813 million in 1987.

Source: Congressional Budget Office and Office of the Actuary, SSA.

Sensitivity of HI trust funds balances to different outlay growth assumptions

Table 11 presents alternative projections of Hospital Insurance (HI) trust fund outlay growth through 1990. All of these projections assume the economic projections underlying the baseline path. The alternatives all are arranged in the table from least to most growth. The alternatives are of two forms. Under one form, hospital outlays are projected to grow by 1, 2, or 3 percent less and 1, 2 or 3 percent more than the baseline in each year. These changes could be due to variations in hospital rate increases, admission patterns, intensity or change in case mix, or technology changes. The percentage refers to entire hospital outlays and not just those outlays covered by the prospective payment system. The second alternative form includes two options which are specific to the prospective payment hospitals and hospitals in waivered States. The two alternatives included here are 1 percentage point higher and lower each year than currently assumed in baseline. Baseline assumes an increase of MB + .25 in 1986 and beyond, so that the two alternatives are MB −.75 and MB + 1.25.

Income to the trust fund is the same (except for interest which varies by size of trust fund balance) in each projection. Under the least growth alternative, expenditures are $67.1 billion in fiscal year 1990 compared to $77.4 billion in the baseline projection. Trust fund balances are $31 billion greater in this alternative.

Conversely, under the alternative with the most growth, expenditures are $11.6 billion higher and trust fund balances $36 billion smaller in 1990.

TABLE 11.—ALTERNATIVE PROJECTIONS OF HOSPITAL INSURANCE OUTLAY GROWTH AND YEAR-END BALANCES[1]

[By fiscal year, in billions of dollars]

	1985	1986	1987	1988	1989	1990
3 percent less hospital outlays each year:						
Outlays	47.9	50.0	53.8	57.8	62.3	67.1
End-of-year balance	22.3	34.1	49.0	59.1	69.8	81.6
2 percent less hospital outlays:						
Outlays	47.9	50.5	54.8	59.5	64.7	70.4
End-of-year balance	22.3	33.6	47.3	55.6	63.3	71.1
1 percent less hospital outlays:						
Outlays	47.9	51.0	55.9	61.2	67.2	73.8
End-of-year balance	22.3	33.1	45.7	51.9	56.7	60.3
Market basket −.75:						
Outlays	47.9	51.2	56.3	61.9	68.3	75.3
End-of-year balance	22.3	32.9	44.9	50.4	54.0	55.7
Baseline:						
Outlays	47.9	51.5	56.9	63.0	69.8	77.4
End-of-year balance	22.3	33.3	44.8	49.2	51.0	50.2
Market basket +1.25:						
Outlays	47.9	51.7	57.5	64.1	71.5	79.7
End-of-year balance	22.3	32.4	43.2	46.2	46.0	42.4
1 percent more hospital outlays:						
Outlays	47.9	52.0	58.0	64.8	72.5	81.1
End-of-year balance	22.3	32.1	42.3	44.5	43.1	37.7

TABLE 11.—ALTERNATIVE PROJECTIONS OF HOSPITAL INSURANCE OUTLAY GROWTH AND YEAR-END BALANCES[1]—Continued

[By fiscal year, in billions of dollars]

	1985	1986	1987	1988	1989	1990
2 percent more hospital outlays:						
Outlays	47.9	52.5	59.1	66.6	75.2	85.0
End-of-year balance	22.3	31.6	40.6	40.8	36.1	26.0
3 percent more hospital outlays:						
Outlays	47.9	52.9	60.2	68.5	78.1	89.0
End-of-year balance	22.3	31.1	38.9	36.9	28.9	14.0

[1] Projections assume economic assumptions underlying CBO's baseline path.

Source: Congressional Budget Office.

Projections to 1995

In September 1984, the Congressional Budget Office presented testimony to the Committee on Ways and Means in which they projected HI hospital outlay revenues, and trust fund balances. In September, CBO assumed the following:

"The basic cost of providing hospital care is estimated from the cost of a market basket of goods and services purchased by hospitals. Labor costs, which account for almost two-thirds of the total market basket, are assumed to grow at an average rate of more than 6 percent per year. The costs of capital goods and supplies—the remaining items in the market basket—are assumed to grow at the same rate as consumer prices in general. * * *

"In 1986, the increase in the DRG rate cannot exceed the market basket increase plus 0.25 percent, as specified by the Deficit Reduction Act. After 1986, the Secretary will determine increases in the DRG rates in consultation with the Prospective Payment Commission. CBO's projected HI increases beyond 1986 assume a growth rate equal to the market basket rate plus 1 percent, following the convention used by the HI actuaries. The additional 1 percent is designed to allow for improvements in medical technology. These estimated increases in the DRG rate can be thought of as the increases in the unit costs of covered hospital activities.

"HI outlays will grow more rapidly than these unit costs, however. Additional annual increases in HI outlay growth stem from increases in program enrollment and in hospital admission rates. These are projected to be 2 percent and 1 percent per year, respectively. Finally, CBO's projections include another cost increase of 1.5 percent per year to allow for other growth in Medicare hospital reimbursement not specifically limited by the Secretary. This growth, for example, could be the result of changes in hospital admitting practices that change the mix of procedures performed, thereby increasing the average cost per admission. In response to the implementation of the DRG system, this residual growth is projected to be slightly lower than in past experience. Combined, these yield an average total outlay growth of 11.8 percent per year."

The prime difference in CBO's latest projections is to assume that the DRG rates will be market basket plus 0.25 instead of 1.

In the absence of CBO projections to 1995, committee staff extrapolated the lastest CBO projections from 1991 to 1995. This extrapolation was done by assuming that the rate of growth in outlays between 1989 and 1990 would remain the same over the next 5 years. A similar assumption was made with respect to income. These results are shown in the last row of table 12. To emphasize the large degree of error involved in making projections to 1995, the projections are shown in a $20 billion range.

The projections in table 12 indicate that insolvency of the HI trust fund is postponed until the early to middle portion of the 1990's. It should be emphasized that even assuming a 1 percent lower or higher hospital outlay growth path relative to the baseline does not change appreciably the estimated date when the HI trust fund is exhausted. Under these committee staff extrapolations of CBO projections to 1990, the HI fund is exhausted in 1995 under the baseline path; 1993 under a 1 percent higher outlay growth rate than assumed in the baseline path; and in 1998 under a 1 percent lower growth rate in outlays relative to the baseline.

TABLE 12.—PROJECTIONS OF HI OUTLAY AND TRUST FUND BALANCES TO 1995 BASED UPON CBO's, JANUARY 1985 PROJECTIONS

	Baseline path		Baseline path—Assuming 1 percent less increase		Baseline path—Assuming 1 percent more increases	
	Outlays	Year-end balance	Outlays	Year-end balance	Outlays	Year-end balance
Original September testimony:						
1989	74	51	70	60	77	41
1990	82	48	78	62	87	33
1995	146	−56	132	21	160	−138
January 1985 estimates:						
1989	70	51	67	57	73	43
1990	77	50	74	60	81	38
1995 [1]	120 to 140	0 to −20	110 to 130	40 to 60	130 to 150	−70 to −90

[1] Estimates made by committee staff by extrapolating the same growth rate between 1989 and 1990 assumed by CBO in this most recent projection throughout the period from 1991 to 1995 for both income and outlays.

However, all of these estimates are highly uncertain. As CBO indicated in their September testimony:

"Estimates of the financial status of the trust fund are very sensitive to the projected growth rate of outlays. Unfortunately, recent reimbursement patterns to hospitals have heightened our uncertainty about such projections.

* * * * * * *

"For projection purposes, the problem is to separate out temporary adjustment factors from long-term improvements in the hospital cost picture. Because the prospective payment system is new, hospitals can be expected to go through some temporary adjustments that involve learning the mechanics of the system, understanding where the rate structure is most binding, and so forth. These factors, which might initially hold down HI outlays, should lessen over time and would therefore not affect the long-run performance of the system.

"On the other hand, many changes have been occuring in the hospital industry that might have more enduring effects on cost growth. For example, in partial response to consumer, business, and government concerns over rising health care costs, many new health organizations are being formed. Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and state and local government cost control plans are growing in size and importance. These groups could affect both hospital admissions rates and hospital costs. Simultaneously, during the last year there has been an unexpected slip in the rate of increase of hospital admissions for those age 65 and older. This decline in the rate of growth of admissions is the opposite of what many observers thought would result from DRG pricing—namely, that hospitals would increase admissions to compensate for lower per-admission reimbursements. All of these factors make forecasting the growth in health-care costs over the next decade a very uncertain task.

"Several examples of uncertainty in the forecasts can be cited—namely, that arising from DRG rate increases, that arising from how the system and other factors affect hospital use, and, to a lesser extent, that arising from the underlying macroeconomic forecasts.

DRG rate increases

"While rate increases for 1985 are now known, those for 1986 and beyond remain uncertain. The Deficit Reduction Act caps the 1986 growth on the DRG rate at that of the market basket plus 0.25 percent, and the CBO baseline assumes that the actual increase will equal this cap. After 1986, no limits are specified by law, and the Secretary of Health and Human Services must specify the annual changes. The Secretary thus has discretionary power over future increases, although payments will almost certainly reflect movements in aggregate hospital costs.

Effect of DRGs and other factors on hospital use

"Perhaps the greatest uncertainty, however, revolves around how hospitals react to the DRG system and other pressures in terms of hospital utilization, admitting practices, and pattern of admissions. For example, hospitals could switch certain diagnoses from out-patient to in-patient care, or vice versa. Hospitals could also continue a movement toward a more complex caseload mix, a trend that has already been observed. With the system not yet fully in place, however, it is still too early to determine the effect of DRGs on hospital behavior."

II. NATIONAL HEALTH CARE EXPENDITURES AND EXPENDITURES FOR HEALTH CARE OF THE ELDERLY

NATIONAL HEALTH EXPENDITURES

During 1965 (the year prior to the beginning of the Medicare and Medicaid programs), national health expenditures were $41.9 billion; by 1983, annual expenditures were $355.4 billion, over eight times that amount. Hospital care expenditures are the largest component of national health expenditures, representing 41.4 percent of total national health spending in 1983. In terms of per capita spending, $629 was spent for hospital care per capita in 1983 compared to $574 in 1982, an increase of 9.6 percent (see table 1).

Of the various sources of payment for personal health care expenditures in 1983, 31.9 percent ($100 billion) was paid for by private health insurance, 18.3 percent ($57.4 billion) was paid by Medicare, 11.4 percent ($35.5 billion) was paid from other Federal sources (including Medicaid), 10.0 percent ($31.5 billion) was paid from State and local sources, and 27.2 percent ($85.2 billion) was paid by direct (out-of-pocket) payments by individuals.

TABLE 1.—NATIONAL HEALTH EXPENDITURES: AGGREGATE AND PER CAPITA AMOUNTS FOR SELECTED CALENDAR YEARS 1965, 1970, 1975, 1980, AND 1983

	1965	1970	1975	1980	1983
	Amount (billions)				
Total	$41.9	$75.0	$132.7	$248.0	$355.4
Percent of GNP	6.1	7.6	8.6	9.4	10.8
Health services and supplies	$38.4	$69.6	$124.3	$236.1	$340.1
Personal health care	35.9	65.4	117.1	219.1	313.3
Hospital care	14.0	28.0	52.4	101.3	147.2
Physicians' services	8.5	14.3	24.9	46.8	69.0
Dentists' services	2.8	4.7	8.2	15.4	21.8
Other professional services	1.0	1.6	2.6	5.6	8.0
Drugs and medical sundries	5.2	8.0	11.9	18.5	23.7
Eyeglasses and appliances	1.2	1.9	3.2	5.1	6.2
Nursing home care	2.1	4.7	10.1	20.4	28.8
Other health services	1.1	2.1	3.8	5.9	8.5
Expenses for prepayment and administration	1.7	2.8	4.0	9.2	15.6
Government public health activities	.8	1.4	3.2	7.7	11.2
Research, and construction of medical facilities	3.5	5.4	8.4	11.9	15.3

TABLE 1.—NATIONAL HEALTH EXPENDITURES: AGGREGATE AND PER CAPITA AMOUNTS FOR SELECTED CALENDAR YEARS 1965, 1970, 1975, 1980, AND 1983—Continued

	1965	1970	1975	1980	1983
	Dollar amount per capita				
Total	$206.40	$350.50	$590.30	$1,049.10	$1,458.90
Health services and supplies	189.20	325.20	552.90	998.70	1,396.10
Personal health care	176.80	305.60	520.90	926.80	1,286.10
Hospital care	69.00	130.80	233.10	428.50	604.30
Physicians' services	41.90	66.80	110.80	198.00	283.30
Dentists' services	13.80	22.00	36.50	65.10	89.50
Other professional services	4.90	7.50	11.60	23.70	32.80
Drugs and medical sundries	25.60	37.40	52.90	78.30	97.30
Eyeglasses and appliances	5.90	8.90	14.20	21.60	25.50
Nursing home care	10.30	22.00	44.90	86.30	118.20
Other health services	5.40	9.80	16.90	25.00	34.90
Expenses for prepayment and administration	8.40	13.10	17.80	38.90	64.00
Government public health activities	3.90	6.50	14.20	32.60	46.00
Research, and construction of medical facilities	17.20	25.20	37.40	50.30	62.80

Source: Gibson, Robert M., Katharine R. Levit, Helen Lazenby, and Daniel R. Waldo. "National Health Expenditures, 1983." Health Care Financing Review, Fall 1984, p. 1.

TABLE 2.—PERSONAL HEALTH CARE EXPENDITURES: AGGREGATE AMOUNTS AND PERCENTAGE DISTRIBUTION FOR SELECTED CALENDAR YEARS 1965, 1970, 1975, 1980, AND 1983

	1965	1970	1975	1980	1983
	Amount in billions				
Total	$35.9	$65.4	$117.1	$219.1	$313.3
Private	28.0	42.9	70.8	132.4	188.9
Private health insurance	8.7	15.3	31.2	67.3	100.0
Patient direct payments	18.5	26.5	38.0	62.5	85.2
Philanthropy and in-plant health services	0.8	1.1	1.6	2.6	3.7
Public	7.9	22.4	46.3	86.7	124.5
Federal	3.6	14.5	31.4	62.5	93.0
State and local	4.3	7.9	14.9	24.2	31.5
	Percentage distribution				
Total	100.0	100.0	100.0	100.0	100.0
Private	78.0	65.6	60.5	60.4	60.3
Private health insurance	24.2	23.4	26.7	30.7	31.9
Patient direct payments	51.6	40.5	32.5	28.5	27.2
Philanthropy and in-plant health services	2.2	1.7	1.3	1.2	1.2
Public	22.0	34.3	39.5	39.6	39.7
Federal	10.1	22.2	26.8	28.5	29.7

TABLE 2.—PERSONAL HEALTH CARE EXPENDITURES: AGGREGATE AMOUNTS AND PERCENTAGE DISTRIBUTION FOR SELECTED CALENDAR YEARS 1965, 1970, 1975, 1980, AND 1983—Continued

	1965	1970	1975	1980	1983
State and local	11.9	12.1	12.7	11.0	10.1

Source: Gibson, Robert M., Katharine R. Levit, Helen Lazenby, and Daniel R. Waldo. "National Health Expenditures, 1983." Health Care Financing Review, Fall 1984, p. 1.

EXPENDITURES FOR HOSPITAL CARE

During 1965 (the year prior to the beginning of the Medicare and Medicaid programs), national expenditures for hospital care amounted to $13 billion. By 1983, annual expenditures had reached $147.2 billion, over 10 times the 1965 amount. Total hospital inpatient expenditures have been increasing rapidly for many years.

From 1970 to 1977, inpatient expenditures in community hospitals grew at an average annual rate of 14.6 percent. After a marked slowing in 1978 and 1979, growth accelerated rapidly and reached an annual rate of 18.4 percent in 1981. Since 1981, the annual rate of increase in inpatient hospital expenses has been declining steadily, following the decline in overall inflation in the economy. During 1982, community inpatient expenditures slowed to an annual increase of 15.5 percent. During 1983, the rate of increase dropped to 9.6 percent.

This rapid growth in hospital costs has led to substantial increases in Federal spending for Medicare and Medicaid, of which roughly 60 percent is for hospital care. Federal outlays under these programs for hospital care totaled approximately $45.3 billion in 1983, an increase of nearly $3 billion from 1981.

Under the current policies, rapidly rising hospital costs and increasing Federal outlays are likely to continue. Projections show that Medicare outlays for hospital care will rise at an average annual rate of approximately 11.5 percent from 1985 through 1988.

Although the high rates of growth in hospital costs are due primarily to increases in prices faced by hospitals, inflation does not explain the most recent surge in Medicare hospital expenditures. The cost of hospital care has typically increased more than the "hospital market basket," which measures changes in the prices of goods purchased by hospitals. This index increased by 11.8 percent in 1981, 9.3 percent in 1982, and 6.3 percent in 1983, whereas Medicare inpatient expenditures increased by 21.6 percent, 17.6 percent, and 13.2 percent in those periods respectively.

There are a variety of factors other than overall inflation which contribute to aggregate changes in hospital expenses. These factors include: population growth, factors such as aging of the population which affect admission rates, inflation in the prices of goods and services purchased by the hospitals (input factor prices) over and above general inflation, and changes in the type and mix (intensity) of services rendered due to such factors as changes in the use of technology or treatment patterns. It has been estimated that 51.6

percent of the overall growth in inpatient hospital expenses between 1972 and 1982 was due to overall inflation, 6.9 percent to population growth, 6.8 percent to increases in admissions per capita, 13.0 percent additional inflation in hospital input prices relative to overall inflation in the general economy, and 21.7 percent to intensity of services per admission.[1]

TABLE 3.—HISTORICAL AND PROJECTED INCREASES IN HI HOSPITAL INPATIENT EXPENDITURES, BY COMPONENT OF INCREASE, 1974–90

[Percent increase over previous year]

Calendar year	HI hospital inpatient expenditures	HI inpatient admission volume	Hospital market basket index	Service intensity and productivity [1]
		Historical Rates		
1974	23.6	5.9	10.4	5.7
1975	22.5	3.5	10.9	6.8
1976	19.0	4.4	8.2	5.4
1977	17.3	7.6	7.4	1.5
1978	14.8	0.9	8.2	5.3
1979	16.4	5.7	9.6	0.5
1980	20.3	4.6	11.6	3.0
1981	21.6	3.7	11.8	4.9
1982	16.1	4.0	9.4	2.0
1983	13.0	4.6	6.2	1.7
		Projected Rates [2]		
1984	11.8	3.8	5.9	1.7
1985	12.5	4.1	7.1	0.9
1986	13.0	4.0	7.7	0.9
1987	12.3	3.5	7.4	1.0
1988	11.8	3.4	7.1	0.9
1989	11.2	3.3	6.6	0.9
1990	10.9	3.3	6.3	1.0

[1] A residual category; that part of annual growth in HI hospital inpatient expenditures not accounted for by growth in HI admissions or increases in the market basket index.

[2] Based on alternative II–B economic assumptions.

Source: Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, 1984, table A1, p. 53.

EXPENDITURES FOR PHYSICIANS' SERVICES

Personal health care expenditures for physicians' services were $69 billion in 1983, an increase of 11.7 percent from the previous year (see table 1). In 1983, 22.0 percent of personal health care expenditures and 19.4 percent of all national health expenditures were for physicians' services. Physicians, however, affect personal health care expenditures more than this might indicate. Physicians have considerable discretion in determining price and volume of all medical services. It is estimated that physicians' decisions (such as ordering hospitalizations, drugs, laboratory tests) directly influence over 70 percent of all health care spending.

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[1] Freeland, Mark S., and Carol E. Schendler. "Health Spending in the 1980's: Integration of Clinical Practice Patterns with Management." Health Care Financing Review, Spring 1984, p. 18.

Third-party (public expenditures and private insurance) payments financed a large majority of physicians' services. Private health insurance paid $30.1 billion (44 percent) for such services. The remainder was split relatively evenly between direct patient payments and public expenditures. Patients or their families paid $19.6 billion (28 percent) for physicians' services. Public programs paid $19.3 billion (28 percent) for such services, of which $13.4 billion (19 percent) was composed of Federal Medicare payments.

Inflation was a major cause of growth in spending for physicians' services. Physicians' fees have risen more rapidly (7.7 percent in 1983) than prices in the economy as a whole (3.2 percent in 1983), as measured by the Consumer Price Index (CPI) (see table 5).

Expenditures for physicians' services over a 10-year span increased from $17 billion in 1972 to $62 billion in 1982, an annual growth rate of about 14 percent. Of this expenditure growth, increases in overall inflation accounted for 57 percent, increases in the CPI for physicians' fees accounted for 13 percent, increases in visits accounted for 3 percent, and increased intensity per visit for 27 percent.

The average 1983 net income after expenses but before taxes for physicians was $106,300, an increase of 6.8 percent over the previous year (see table 6). Surgeons had the highest average net income ($138,900) among the specialty groups and experienced the highest growth, 9.6 percent, in average net income. In contrast, the average net income of general and family practitioners fell 4.7 percent (to $68,500). By region, average net income growth rates varied by less than 1 percent, ranging from 6.4 percent in the North Central States to 7.3 percent in the West. As a result, physicians in the South and North Central regions continued to have the highest average net incomes ($113,400 and $113,100), physicians in the West were in the middle of the range ($100,100), and physicians in the Northeast had the lowest average net income ($94,500). The growth rates differed more noticeably between rural and urban areas, ranging from 0.3 percent in nonmetropolitan areas to 6.8 percent and 8.0 percent for metropolitan areas with less than and more than 1 million population. The average net income of self-employed physicians ($115,900) continued to be higher than the average net income of employee physicians ($77,600) although the 6.3 percent growth rate in self-employed physicians' net income was lower than the 8.5 percent growth rate for employee physicians.

The 1982 continuing survey of physicians' income conducted by Medical Economics [2] showed that the typical office-based doctor received two-thirds of his 1981 gross practice income from third parties (see table 7). On the average, 21 percent came from commercial health insurance, 20 percent from Blue Shield, 17 percent from Medicare, and 8 percent from Medicaid. Table 7 also shows the breakdown of gross practice income from each third party. For example, thoracic surgeons on average receive 35 percent ($72,420 per capita) of their gross income from Medicare, while pediatricians on average gain only 1 percent ($1,170 per capita) of their gross incomes from Medicare.

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[2] Owens, Arthur. "How Much of Your Income Comes From Third Parties?" in Medical Economics, April 4, 1983.

TABLE 4.—PERSONAL HEALTH CARE EXPENDITURES FOR PHYSICIAN SERVICES [1] BY SELECTED THIRD-PARTY PAYERS: CALENDAR YEARS 1981–83

[Amounts in billions]

Source of payment	1981		1982		1983	
	Amount	Percent	Amount	Percent	Amount	Percent
Total	$54.8	100.0	$61.8	100.0	$69.0	100.0
Direct payments	16.3	29.7	17.8	28.8	19.6	28.4
Third-party payments	38.5	70.3	44.0	80.3	49.5	71.7
Private health insurance	23.4	42.7	27.1	43.8	30.1	43.6
Philanthropy and industrial inplant	(2)	(2)	(2)	(2)	(2)	(2)
Government	15.0	27.4	16.9	27.3	19.3	28.0
Federal	11.7	21.3	13.4	21.7	15.6	22.6
Medicare [3]	9.7	17.7	11.4	20.8	13.4	19.4
Medicaid [4]	1.5	2.7	1.5	2.4	1.6	2.3
Other	.5	.9	.5	.8	.6	.9
State and local	3.3	6.0	3.5	5.7	3.7	5.4
Medicaid [4]	1.2	2.2	1.3	2.4	1.4	2.0
Other	2.1	3.8	2.2	3.5	2.3	3.3

[1] Encompasses the cost of all services and supplies provided in physicians' offices, the cost for services of private practitioners in hospitals and other institutions, and the cost of diagnostic work performed in independent clinical laboratories. The salaries of staff physicians are counted with expenditures for the services of the employing institution.

[2] Less than $50 million.

[3] Represents total expenditures from funds for benefits. Trust fund income includes premium payments paid by or on behalf of enrollees.

[4] Includes funds paid into Medicare trust funds by States under "buy-in" agreements to cover premiums for public assistance recipients and for persons who are medically indigent.

Source: Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy. Health Care Financing Administration as reported in Gibson, Robert M., Katharine R. Levit, Helen Lazenby, and Daniel R. Waldo. "National Health Expenditures, 1983." Health Care Financing Review, winter 1984, p. 1.

TABLE 5.—ANNUALIZED RATES OF CHANGE IN THE CONSUMER PRICE INDEX (CPI–U) [1] 1965–84

	CPI all items	CPI, all items less medical care	Medical care total	Physicians' services
1965	1.7	1.5	2.5	3.6
1966	2.9	3.0	4.4	5.8
1967	2.9	2.4	7.1	7.1
1968	4.2	4.1	6.1	5.6

TABLE 5.—ANNUALIZED RATES OF CHANGE IN THE CONSUMER PRICE INDEX (CPI–U) [1] 1965–84—Continued

	CPI all items	CPI, all items less medical care	Medical care total	Physicians' services
1969	5.4	5.4	6.9	6.9
1970	5.9	5.8	6.3	7.5
1971	4.3	4.1	6.5	6.9
1972	3.3	3.3	3.2	3.1
1973	6.2	6.4	3.9	3.3
1974	11.0	11.1	9.3	9.2
1975	9.1	8.9	12.0	12.3
1976	5.8	5.5	9.5	11.3
1977	6.5	6.2	9.6	9.3
1978	7.7	7.6	8.4	8.3
1979	11.3	11.4	9.3	9.2
1980	13.5	13.6	10.9	10.6
1981	10.4	10.3	10.8	11.0
1982	6.1	5.9	11.6	9.4
1983	3.2	2.9	8.7	7.7
1984	4.3	4.1	6.2	7.0

[1] CPI index for all urban consumers, unadjusted figures.

Source: U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index, various publications.

TABLE 6.—PHYSICIANS' AVERAGE NET INCOME AFTER EXPENSES BUT BEFORE TAXES, SURVEY RESULTS, 1982 AND 1983

	Average net income [1]		Percent change
	1982	1983	
All physicians [2]	$99,500	$106,300	6.8
Specialty:			
General/family practice	71,900	68,500	−4.7
Medical specialties	81,700	85,600	4.8
Surgical specialties	126,700	138,900	9.6
Region:			
Northeast	88,300	94,500	7.0
North Central	106,300	113,100	6.4
South	105,700	113,400	7.3
West	93,600	100,100	6.9
Location:			
Nonmetropolitan	86,900	87,200	0.3
Metropolitan:			
Less than 1,000,000	103,900	111,000	6.8
1,000,000 and over	98,400	106,300	8.0
Employment status:			
Self-employed	109,000	115,900	6.3
Employee	71,500	77,600	8.5

[1] Average net income after expenses but before taxes. These figures include contributions made into pension, profit-sharing, and deferred compensation plans.

[2] Includes physicians in specialties not reported separately.

Source: SMS Report, Socioeconomic Monitoring System, American Medical Association, Vol. 3, No. 5, August 1984.

TABLE 7.—NET PRACTICE EARNINGS OF PHYSICIANS NATIONWIDE FROM 16 SPECIALTIES, SURVEY RESULTS, 1981

	Commercial plans		Blue Shield		Medicare		Medicaid	
	Amount per capita	As percent of gross	Amount per capita	As percent of gross	Amount per capita	As percent of gross	Amount per capita	As percent of gross
Anesthesiologists	$40,880	27	$43,750	29	$32,790	22	$12,970	10
Family practitioners	25,110	17	18,390	13	21,220	15	12,370	9
General practitioners	22,620	17	16,800	13	21,170	18	12,250	10
General surgeons	47,700	26	45,570	27	43,750	25	13,190	8
Internists	20,870	15	26,420	19	39,630	29	8,740	7
Neurologists	34,070	22	32,860	22	37,390	24	12,040	9
Neurosurgeons	67,040	32	57,220	28	37,310	18	14,920	8
Obstetricians/gynecologists	59,690	32	55,070	30	8,530	5	15,450	8
Ophthalmologists	18,900	10	21,610	11	49,010	24	12,770	8
Orthopedic surgeons	76,920	31	58,050	25	43,220	17	14,390	6
Pathologists	18,420	14	34,850	26	28,000	21	13,330	11
Pediatricians	16,750	14	12,080	12	1,170	1	10,950	9
Plastic surgeons	43,870	25	34,670	22	18,780	12	8,710	5
Psychiatrists	25,370	24	20,140	19	6,370	6	5,340	5
Radiologists	32,840	18	51,420	28	49,730	28	18,450	11
Thoracic surgeons	43,110	21	57,990	26	72,420	35	15,930	7
All surgical specialists	50,950	26	48,010	25	38,910	20	13,540	8
All non-surgical specialists	25,710	19	27,430	20	24,660	17	10,710	8
All M.D.'s	33,480	21	32,030	20	27,490	17	11,440	8

Source: Medical Economics Continuing Survey, 1982, as reported in Owens, Arthur. "How Much of Your Income Comes From Third Parties?" Medical Economics, April 4, 1983.

HEALTH CARE EXPENDITURES FOR THE ELDERLY

Expenditures for personal health care services for the elderly have nearly tripled over the last 7 years, rising from $43 billion in 1977 to an estimated $120 billion in 1984 (see table 8). Per capita spending rose an average of 13 percent annually during those years, from $1,785 to $4,202 (see table 9).

Government programs (Federal and State) account for two-thirds ($2,823 per capita) of estimated 1984 spending for the aged (see table 10). The most significant of these programs is Medicare which pays for nearly half ($2,051 per capita) of the aged's health bill. Medicaid funds about 13 percent ($536 per capita) of the expenditures. Other Government health programs are the source of roughly 6 percent ($236 per capita) of personal health care expenditures for people 65 years of age and over.

Consumers are responsible for the remaining one-third ($1,379 per capita) of spending for the aged. One-quarter ($1,059 per capita) of the total health bill for the aged was paid by direct patient payments, also termed out-of-pocket expenses. Out-of-pocket payments by the elderly represent the difference between total health expenditures by the aged and known third-party (public expenditures and private insurance) payments. These out-of-pocket payments include Medicare copayments (less any benefits paid for by so-called "medigap" policies), collected reasonable charge reductions, net private health insurance copayments, and the purchase of care not covered by any third party. It is important to note that direct out-of-pocket payments to providers are not the only expenditures by the aged for health care. The aged also pay supplementary medical insurance (SMI or part B) and private health insurance premiums which are not defined as out-of-pocket expenditures. Private health insurance, including medigap policies, covers an additional estimated 7 percent ($304 per capita) of personal health care expenditures for the elderly.

It is difficult to estimate precisely the share of the elderly's income which is spent on health care. There are little data available which examine this question directly. Therefore, these estimates require many assumptions and must be based on data from a variety of sources. The House Select Committee on Aging and the Senate Special Committee on Aging each have developed estimates of these amounts. They both estimated that the elderly's out-of-pocket health care costs as a percentage of mean income were about 12 percent in 1977 and about 15 percent in 1984.[1]

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[1] House Select Committee on Aging, press release, October 31, 1984. Senate Special Committee on Aging, Medicare and the Health Costs of Older Americans: The Extent and Effects of Cost Sharing, committee print, April 1984.

TABLE 8.—PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE, 1977 AND 1984

[In millions of dollars]

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1977					
Total	43,425	18,906	7,782	10,696	6,041
Private	15,669	2,319	3,323	5,424	4,603
Consumer	15,499	2,263	3,320	5,352	4,564
Out-of-pocket	12,706	927	2,147	5,264	4,368
Insurance	2,793	1,336	1,173	88	195
Other private	170	56	3	72	39
Government	27,756	16,587	4,458	5,272	1,438
Medicare	19,171	14,087	4,158	348	578
Medicaid	6,049	733	232	4,453	631
Other government	2,536	1,767	68	470	230
Exhibit: Population (in millions)	24.3				
1984					
Total	119,872	54,200	24,770	25,105	15,798
Private	39,341	6,160	9,827	13,038	10,316
Consumer	38,875	5,964	9,818	12,856	10,237
Out-of-pocket	30,198	1,694	6,468	12,569	9,467
Insurance	8,677	4,270	3,350	287	770
Other private	466	196	9	182	79
Government	80,531	48,040	14,943	12,067	5,482
Medicare	58,519	40,524	14,314	539	3,142
Medicaid	15,288	2,595	467	10,418	1,808
Other government	6,724	4,920	162	1,110	532
Exhibit: Population (in millions)	28.5				

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration as reported in Waldo, Daniel R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review, fall 1984, p. 1.

TABLE 9.—PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE, 1977 AND 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing	Other care
1977					
Total	$1,785	$777	$230	$440	$248
Private	644	95	137	223	189
Consumer	637	93	136	220	188
Out-of-pocket	522	38	88	216	180
Insurance	115	55	48	4	8
Other private	7	2	(1)	3	2
Government	1,141	682	183	217	59
Medicare	788	579	171	14	24
Medicaid	249	30	10	183	26
Other government	104	73	3	19	9
1984					
Total	4,202	1,900	868	880	554
Private	1,379	216	344	457	362
Consumer	1,363	209	344	451	359
Out-of-pocket	1,059	59	227	441	332
Insurance	304	150	117	10	27
Other private	16	7	(1)	6	3
Government	2,823	1,684	524	423	192
Medicare	2,051	1,420	502	19	110
Medicaid	536	91	16	365	63
Other government	236	172	6	39	19

(1) Less than $.50.

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration as reported in Waldo, Daniel, R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review, fall 1984, p. 1.

TABLE 10.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: 1977 AND 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1977					
Total per capita	100.0	100.0	100.0	100.0	100.0
Private	36.1	12.3	42.7	50.7	76.2
Consumer	35.7	12.0	42.7	50.0	75.5
Out-of-pocket	29.3	4.9	27.6	49.2	72.3
Insurance	6.4	7.1	15.1	0.8	3.2
Other private	0.4	0.3	.0	0.7	0.6
Government	63.9	87.7	57.3	49.3	23.8
Medicare	44.1	74.5	53.4	3.3	9.6
Medicaid	13.9	3.9	3.0	41.6	10.4
Other government	5.8	9.3	0.9	4.4	3.8
1984					
Total per capita	100.0	100.0	100.0	100.0	100.0
Private	32.8	11.4	39.7	51.9	65.3
Consumer	32.4	11.0	39.6	51.2	64.8
Out-of-pocket	25.2	3.1	26.1	50.1	59.9
Insurance	7.2	7.9	13.5	1.1	4.9
Other private	0.4	0.4	.0	0.7	0.5
Government	67.2	88.6	60.3	48.1	34.7
Medicare	48.8	74.8	57.8	2.1	19.9
Medicaid	12.8	4.8	1.9	41.5	11.4
Other government	5.6	9.1	0.7	4.4	3.4

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration as reported in Waldo, Daniel, R., and Helen C. Lazenby. "Demographic characteristic and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review, fall 1981, p. 1.

EXPENDITURES FOR HOSPITAL CARE BY THE ELDERLY

Medicare is now paying a slightly larger proportion of the hospital bills for the aged. In 1977, $18.9 billion was spent on hospital care for persons 65 and over. Of this amount, the Medicare program paid $14.1 billion, or 74.5 percent. In 1984, hospital care expenditures for the aged are estimated to be $54.2 billion; the Medicare program is estimated to pay $40.5 billion or 74.8 percent of all hospital care expenditures for the aged (see tables 8–10).

It is estimated that approximately 69 percent of all Medicare benefits in 1984 went for hospital care ($40.5 billion out of a benefit total of $58.5 billion). This percentage is slightly lower than in 1970, when 71.8 percent of Medicare benefits went for hospital care ($5.1 billion out of a benefit total of $7.1 billion).

Total Medicare reimbursement to short-stay hospitals more than quadrupled from 1970 to 1981, increasing from $4.5 billion to $24.7 billion, an average annual increase of approximately 15 percent. During this period, the average reimbursement to short-stay hospitals per discharged Medicare enrollee rose from $763 to $2,434, despite a decrease from 13.1 days to 10.3 days in the average length of stay for each discharged enrollee. The average reimbursement per hospital day covered by the program increased from $60 in 1970 to $241 in 1981. The increase in Medicare short-stay hospital reimbursements between 1970 to 1981 was primarily a function of the increased cost of hospital care as measured by reimbursement per covered day (see table 11).

TABLE 11.—USE OF SHORT STAY HOSPITAL SERVICES BY MEDICARE HOSPITAL INSURANCE (HI) BENEFICIARIES: NUMBER OF HI ENROLLEES AND DISCHARGES, DAYS OF CARE, CHARGES, AND REIMBURSEMENT, CALENDAR YEARS, 1970–81 [1]

Year	Number of enrollees	Number of discharges	Mean length of stay (in days)		Days of care			Total charges			Reimbursement		
			Total	Covered	Total number (thousands)	Covered		Amount (thousands)	Per discharge	Per day	Amount (thousands)	Per discharge	Percent of total charges
			Amount (thousands)	Per discharge		Number (thousands)	Percent of total days						
1970 [2]	20,361,152	5,920,320	13.1	12.8	77,652	75,914	97.7	$5,903,690	$998	$76	$4,517,654	$763	76.4
1971 [2]	20,742,250	6,111,835	12.7	12.3	77,395	75,313	97.3	6,733,494	1,102	87	5,129,245	839	76.1
1972 [2]	21,115,261	6,495,050	12.3	11.8	79,809	76,788	96.2	7,560,301	1,164	95	5,709,189	879	75.5
1973 [2]	23,301,082	6,861,125	11.9	11.3	81,380	77,663	95.4	8,269,144	1,207	102	6,253,014	911	75.6
1974	23,924,145	7,039,345	11.6	11.3	81,766	79,798	97.0	9,779,034	1,389	120	7,346,544	1,044	75.0
1975	24,640,497	7,443,425	11.4	11.2	84,637	83,179	98.0	12,385,397	1,664	146	9,262,624	1,244	74.0
1976	25,312,575	8,361,720	11.3	11.1	94,169	92,578	98.0	16,094,865	1,925	171	11,980,874	1,433	74.0
1977	26,093,919	8,818,735	11.0	10.8	97,025	95,298	98.0	19,205,304	2,178	198	13,974,943	1,585	72.0
1978	26,777,263	9,188,140	10.8	10.6	99,301	97,553	98.0	22,368,244	2,434	225	16,005,245	1,742	71.0
1979	27,459,157	9,623,290	10.7	10.4	102,694	100,271	97.0	26,042,574	2,706	254	18,410,379	1,913	70.0
1980	28,066,894	10,234,980	10.6	10.3	108,531	105,932	97.0	31,792,888	3,106	293	21,967,644	2,146	69.0
1981	28,589,504	10,142,365	10.3	10.1	104,929	102,337	97.0	32,655,713	3,220	311	24,689,269	2,434	75.0

[1] 1970–73 data based on bills processed through December 1980; 1974–1981 data from bills processed through June 1982.

[2] Prior to 1973, services were covered only for beneficiaries aged 65 and over. Effective July 1, 1973, HI benefits were extended to persons under 65 years of age who were entitled to cash benefits for not less than 24 consecutive months under the disability insurance program and to persons with End-Stage Renal Disease (ESRD).

Source: Unpublished data provided by the Bureau of Data Management and Strategy, HCFA, from Medicare Health Insurance Master Files.

EXPENDITURES FOR PHYSICIAN SERVICES BY THE ELDERLY

Total expenditures for physicians' services for the aged grew an average of 18 percent per year from $7.8 billion in 1977 to an estimated level of $24.8 billion in 1984 (see table 9). Medicare was estimated to have paid the largest share, nearly 58 percent, of the $868 per capita projected amount spent by the elderly in 1984. Direct patient payments—including coinsurance, deductibles, and services not covered by third parties—accounted for about 26 percent. Private insurers were estimated to pay almost 14 percent of the total. Government programs other than Medicare, including Medicaid, were estimated to cover about 3 percent. These proportions were similar in 1977.

The percentage of total physician services paid for by Medicare has declined slightly since the early years of the program from 57.3 percent in fiscal year 1968 to 57.8 percent in calendar year 1984. At the same time there has been a significant increase in reasonable charge reductions for unassigned Medicare claims; the average amount reduced per approved unassigned claim was $28.69 in calendar year 1983. These reductions can become an out-of-pocket expense for beneficiaries.

DISTRIBUTION OF PER RECIPIENT MEDICARE EXPENDITURES AND DEDUCTIBLE AND COPAYMENT AMOUNTS

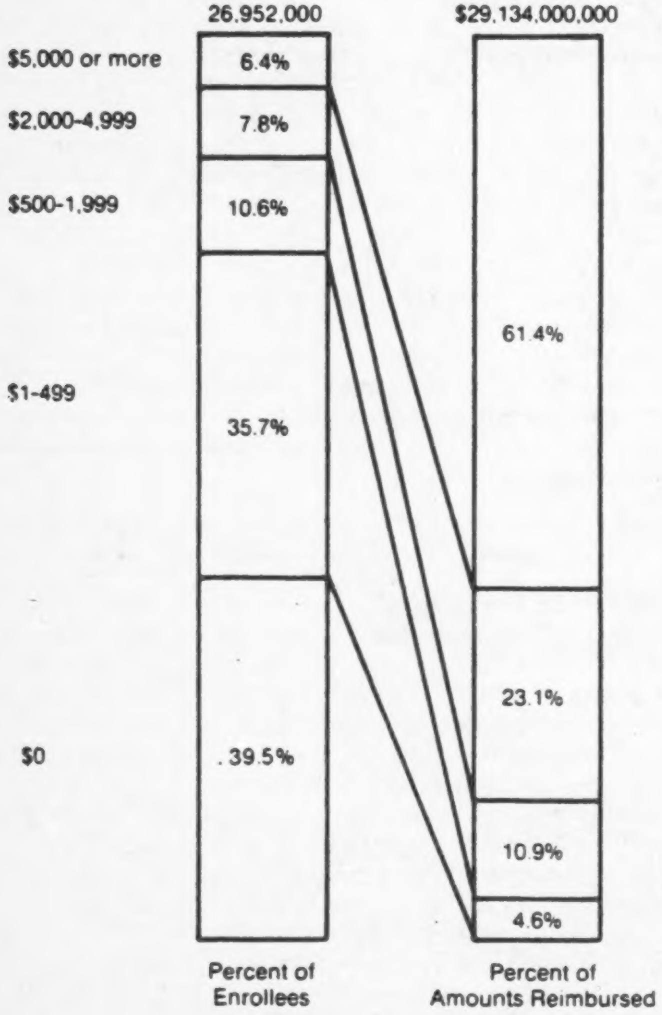
A significant portion of Medicare beneficiaries receive no reimbursement for Medicare services in a given year. Under the part A program in 1983 there were 29.1 million beneficiaries with hospital insurance protection. Of this number only 7.4 million (25.4 percent) received any reimbursed services under part A of the program. Thus, 21.7 million or 74.6 percent of beneficiaries eligible under part A received no reimbursed service.

Under part B of the program in 1983 there were 28.7 million beneficiaries with part B coverage. Of this total, 19.6 million (68.2 percent) received reimbursed services. Thus, 9.1 million or 31.8 percent of eligible beneficiaries under the part B program received no reimbursed services under the program.

Medicare per capita expenditure amounts for the aged do not reflect the considerable variations which exist. In 1980, 75.2 percent of aged persons receiving services reimbursed under parts A and/or B had Medicare reimbursements totaling less than $500; expenditures for these persons accounted for only 4.6 percent of the total amounts reimbursed. On the other hand, 14.2 percent of persons receiving services under parts A and/or B had Medicare reimbursements totaling over $2,000; expenditures for these persons accounted for 84.5 percent of the total (see figure 1).

In 1982, about 33 percent of aged persons had Medicare reimbursements totaling less than $500; expenditures for these persons accounted for 3.5 percent of the total amounts reimbursed. Some 13 percent had Medicare reimbursements totaling over $3,000; expenditures for these persons accounted for 82 percent of the total (see table 12).

FIGURE 1.—Percent Distribution of Aged Persons Served and Amounts Reimbursed Under Hospital Insurance and/or Supplementary Medical Insurance by Amounts Reimbursed, 1980



Source: The Medicare and Medicaid Data Book, 1983, Health Care Financing Program Statistics, HCFA Pub. No. 03156, DHHS, December 1983, p. 28.

The following table provides additional information on the distribution of Medicare and expenditures for the aged.

TABLE 12.—NUMBER AND PERCENTAGE DISTRIBUTION OF AGED PERSONS RECEIVING SERVICES AND AMOUNTS REIMBURSED UNDER HOSPITAL INSURANCE AND/OR SUPPLEMENTARY MEDICAL INSURANCE BY AMOUNTS REIMBURSED, 1982

Item	Enrollees			Reimbursement		
	Number in millions	Percent distribution	Cumulative percent	Amount in millions	Percent distribution	Cumulative percent
1982						
All aged persons enrolled	28.0	100.0		$41,526	100.0	
Persons with no reimbursement	11.0	39.2	100.0			
Persons with reimbursement [1]	17.0	60.8		41,526	100.0	
Reimbursement interval:						
Less than $100	4.1	14.7	60.8	188	0.5	100.0
$100 to $499	5.1	18.2	46.2	1,225	3.0	99.5
$500 to $1,499	2.4	8.4	27.9	2,119	5.1	96.6
$1,500 to $2,999	1.7	6.2	19.5	3,788	9.1	91.5
$3,000 to $4,999	1.3	4.5	13.3	4,954	11.9	82.4
$5,000 to $9,999	1.4	4.9	8.8	9,707	23.4	70.4
$10,000 to $14,999	0.5	1.9	3.9	6,527	15.7	47.1
$15,000 or more	0.5	1.9	1.9	13,017	31.3	31.3

[1] Data include experience for persons who exceeded the annual Medicare deductibles and for whom reimbursements were made.

Note: Based on a 5-percent sample.

Source: Bureau of Data Management and Strategy, Health Care Financing Administration and unpublished data.

The preceding discussion has focused on the distribution of medicare reimbursements. Similar data is also available on the liability of medicare beneficiaries, defined as the deductible and coinsurance amounts. It does not include liability for medical service not covered by Medicare or for any liability due to unassigned Medicare claims. It also does not include part B premiums paid by beneficiaries. In 1980, 75.2 percent of aged persons enrolled in both parts A and B had less than $200 in liability for such expenses. On the other hand, enrollees at the high end of the scale were liable for most of the cost sharing owed.

TABLE 13.—DISTRIBUTION OF MEDICARE ENROLLEES AGED 65 AND DISTRIBUTION OF PART A AND PART B COMBINED LIABILITY, 1980 [1]

Liability category	Distribution of enrollee		Distribution of liability	
	Numbers	Percent	Dollars (thousands)	Percent
Total	25,104,680	100.0	4,513,898	100.0
0 to $69	13,107,540	52.2	473,663	10.5
$70 to $119	3,956,460	15.8	366,081	8.1
$120 to $169	1,428,680	5.7	199,859	4.4
$170 to $179	148,200	.6	25,841	.6
$180 to $189	122,200	.5	22,526	.5
$190 to $199	112,960	.4	21,935	.5
$200 to $209	95,100	.4	19,439	.4

TABLE 13.—DISTRIBUTION OF MEDICARE ENROLLEES AGED 65 AND DISTRIBUTION OF PART A AND PART B COMBINED LIABILITY, 1980 [1]—Continued

Liability category	Distribution of enrollee		Distribution of liability	
	Numbers	Percent	Dollars (thousands)	Percent
$210 to $219	152,840	.6	32,543	.7
$220 to $229	97,400	.4	21,872	.5
$230 to $269	582,120	2.3	146,445	3.2
$270 to $469	2,770,780	11.0	973,879	21.6
$470 to $969	1,979,640	7.9	1,273,110	28.2
$970 to $1,469	341,040	1.4	396,540	8.8
$1,470 and over	209,720	.8	540,166	12.0

[1] Tables adjusted to take into account the missing Part B deductions, estimated to be about $30 per enrollee in 1980.

Source: Gornick, Marian, James Beebe, and Ronald Prihoda, "Options for Change under Medicare Impact of a Cap on Catastrophic Illness Expense." Health Care Financing Review, fall 1983, p. 37.

SUPPLY OF HOSPITAL BEDS AND PHYSICIANS

The national supply of community hospital beds per 1,000 population has steadily increased since the 1940's, reaching a peak of 4.6 beds per 1,000 population in 1975. By 1982, the number of beds had dropped to 4.4 per 1,000 population. Similar trends can be seen in the nine census regions, except for New England, which has seen a reduction since 1940 from 4.4 beds to 4.1 beds per 1,000 population in 1982, and the Pacific region, where the reduction has been from 4.1 beds in 1940 to 3.3 in 1982. The area experiencing the largest increase has been the East South Central, where beds increased from 1.7 per 1,000 population in 1940 to 5.1 in 1982 (see table 14).

TABLE 14.—HOSPITAL BEDS PER 1,000 POPULATION,[1] ACCORDING TO GEOGRAPHIC DIVISION: UNITED STATES, SELECTED YEARS 1940–82

[Data are based on reporting by facilities]

Geographic division	Year						
	1940[2]	1950[2]	1960[3]	1970	1975	1980	1982
United States	3.2	3.3	3.6	4.3	4.6	4.5	4.4
New England	4.4	4.2	3.9	4.1	4.2	4.1	4.1
Middle Atlantic	3.9	3.8	4.0	4.4	4.6	4.6	4.6
East North Central	3.2	3.2	3.6	4.4	4.7	4.7	4.8
West North Central	3.1	3.7	4.3	5.7	5.8	5.8	5.9
South Atlantic	2.5	2.8	3.3	4.0	4.3	4.5	4.4
Eastf South Central	1.7	2.1	3.0	4.4	4.9	5.1	5.1
West South Central	2.1	2.7	3.3	4.3	4.7	4.7	4.4
Mountain	3.6	3.8	3.5	4.3	4.0	3.8	3.6

TABLE 14.—HOSPITAL BEDS PER 1,000 POPULATION,[1] ACCORDING TO GEOGRAPHIC DIVISION: UNITED STATES, SELECTED YEARS 1940–82—Continued

[Data are based on reporting by facilities]

Geographic division	Year						
	1940 [2]	1950 [2]	1960 [3]	1970	1975	1980	1982
Pacific	4.1	3.2	3.1	3.7	3.9	3.5	3.3

[1] Civilian population.
[2] 1940 and 1950 data are estimated based on published figures.
[3] 1960 includes hospital units of institutions.

Note. Hospitals include all non-Federal short-stay hospitals classified by the American Hospital Association according to one of the following services: general medical and surgical; obstetrics and gynecology; eye, ear, nose, and throat, rehabilitation; orthopedic; other specialty; children's general; children's eye, ear, nose, and throat; children's rehabilitation; children's orthopedic; and children's other specialty.

Source: Health, United States, 1984. U.S. Department of Health and Human Services. DHHS Publication No. (PHS) 85–1232, Table 66, pp. 127–128.

The number of active physicians in the country has increased from 279,212 in 1970 to 419,870 in 1981. This growth rate exceeded the rate at which the population of the Nation grew during the decade. As table 15 below indicates, the ratio of physicians-to-population increased from 137 physicians per 100,000 population in 1970 to 206 physicians per 100,00 population in 1982. This table also indicates variations in the supply of physicians relative to population by State. In 1982, the District of Columbia had the highest ratio (573 physicians per 100,000 population) while Idaho had the lowest ratio (124 physicians per 100,000 population).

TABLE 15.—NON-FEDERAL PHYSICIAN/POPULATION RATIOS AND RANK BY STATE

[Ratios: Non-Federal physicians (M.D.'s) per 100,000 civilian population]

Geographic area	1970	1975 [1]	1982	1982 rank
United States [2]	137	156	206	
Alabama	84	100	139	45
Alaska	65	92	134	47
Arizona	123	151	213	13
Arkansas	85	95	140	44
California	175	196	258	6
Colorado	163	172	210	15
Connecticut	178	207	280	5
Delaware	124	138	188	21
District of Columbia	365	436	573	1
Florida	124	155	219	11
Georgia	100	119	156	36
Hawaii	138	160	231	8
Idaho	87	95	124	50
Illinois	130	156	205	16

TABLE 15.—NON-FEDERAL PHYSICIAN/POPULATION RATIOS AND RANK BY STATE—Continued

[Ratios: Non-Federal physicians (M.D.'s) per 100,000 civilian population]

Geographic area	1970	1975 [1]	1982 [2]	1982 rank
Indiana	96	109	143	42
Iowa	97	105	142	43
Kansas	108	128	173	29
Kentucky	96	117	151	39
Louisiana	114	127	170	32
Maine	98	122	180	24
Maryland	171	206	300	3
Massachusetts	194	222	306	2
Michigan	117	135	178	26
Minnesota	142	162	211	14
Mississippi	78	87	120	51
Missouri	120	141	181	23
Montana	97	111	146	41
Nebraska	106	124	162	34
Nevada	102	117	159	35
New Hampshire	125	146	195	20
New Jersey	136	162	220	10
New Mexico	103	121	174	27
New York	223	235	300	4
North Carolina	103	124	170	31
North Dakota	88	104	151	38
Ohio	125	137	183	22
Oklahoma	94	108	138	46
Oregon	133	160	203	17
Pennsylvania	143	158	214	12
Rhode Island	143	175	230	9
South Carolina	85	106	149	40
South Dakota	76	83	131	48
Tennessee	113	134	172	30
Texas	109	129	164	33
Utah	129	150	174	28
Vermont	169	189	250	7
Virginia	113	136	197	19
Washington	136	154	203	18
West Virginia	98	120	153	37
Wisconsin	113	129	178	25
Wyoming	91	100	130	49

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[1] Numbers of active non-Federal physicians are adjusted for 1975 to include about 90 percent of those not classified as to status or activity by the American Medical Association.

[2] Excludes counts of physicians in U.S. possessions and with unknown addresses.

Source: Supply and Characteristics of Selected Health Personnel, U.S. Department of Health and Human Services, Bureau of Health Professions, DHHS Pub. No. (HRA) 81–20, June 1981, p. 23, and unpublished data from the Bureau of Health Professions, based on data from the American Medical Association, Division of Survey and Data Resources. 1982 data from Physician Characteristics and Distribution in the U.S., 1983 Edition, American Medical Association, Division of Survey and Data Resources, Department of Data Release Services.

The number of physicians in the United States is expected to continue to grow at a faster rate than the general population. Department of Health and Human Services' projections of physicians-to-population ratios indicate that there will be 221.2 active physicians (M.D.'s) per 100,000 population in 1985, 238.1 in 1990, 251.8 in 1995, and 263.6 in 2000.

HEALTH INSURANCE COVERAGE OF THE ELDERLY

According to data collected in the March 1984 Current Population Survey, 98.9 percent of persons age 65 and over (or approximately 25 million persons) had medical coverage through either a private source (such as an employer group health plan or other privately purchased health insurance) or through a public program (such as Medicare, Medicaid, CHAMPUS, Veterans Administration, or military health care). As shown in table 16 below, most persons age 65 and over (96.1 percent) are covered under the Medicare program, 60.5 percent are covered under private health insurance plans (either employer group plans or other health insurance) and 11 percent are covered by Medicaid. The nonpoor aged had higher reported rates of coverage for all forms of health coverage, except for Medicaid, than did the aged poor.

TABLE 16.—MEDICAL COVERAGE FOR THE AGED, BY POVERTY STATUS, 1983

[In percent]

	Total	Poor	Nonpoor
Persons age 65 and over (number in thousands)	(26,291)	(3,711)	22,580
Total	100.0	100.0	100.0
No medical coverage	1.1	2.9	.8
Any medical coverage	98.9	97.1	99.2
Employer group health	6.6	.8	7.2
Medicare	96.1	95.4	96.2
Medicaid	11.0	33.2	7.3
CHAMPUS, VA, or military health care	3.3	1.4	3.6
Other health insurance	53.9	26.6	58.4

Source: March 1984 Current Population Survey (CPS). Table prepared by the Congressional Research Service, Education and Public Welfare Division.

III. BRIEF EXPLANATION OF MEDICAID PROGRAM AND INTERACTION WITH AFDC, SSI, AND MEDICARE PROGRAMS

Medicaid

Medicaid, authorized under title XIX of the Social Security Act, is a Federal-State matching program providing medical assistance for low-income persons who are aged, blind, disabled, or members of families with dependent children. Within Federal guidelines, each State designs and administers its own program. Thus there is substantial variation among the States in terms of persons covered, types, and scope of benefits offered, and amounts of payments for services. Public Law 97–35, the Omnibus Budget Reconciliation Act of 1981, authorized reductions in Federal payments to the States over the fiscal year 1982–84 period and provided States with increased flexibility in designing and modifying their programs.

Medicaid eligibility is directly linked to eligibility under programs within the jurisdiction of the Committee on Ways and Means, namely AFDC and SSI. Further, some poor aged persons are covered under both the Medicare and Medicaid programs.

ELIGIBILITY

Eligibility for Medicaid is linked to actual or potential receipt of cash assistance under the federally assisted Aid to Families With Dependent Children (AFDC) program and the Federal Supplemental Security Income (SSI) program for the aged, blind, and disabled; there are two classes of eligibility under medicaid: categorically needy and medically needy.

CATEGORICALLY NEEDY

All States[1] cover the categorically needy under their Medicaid programs. In general, these are persons receiving assistance under AFDC or SSI. States have the option of limiting Medicaid coverage of SSI recipients by requiring them to meet any more restrictive eligibility criterion that was in effect on January 1, 1972 (before implementation of SSI). States choosing the more restrictive criteria must allow applicants to deduct medical expenses from income in determining eligibility. Fourteen States currently employ more restrictive criteria.

These States are:

Connecticut
Hawaii
Illinois
Indiana
Minnesota
Missouri
Nebraska
New Hampshire
North Carolina
North Dakota
Ohio
Oklahoma
Utah
Virginia

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[1] Arizona does not operate a traditional Medicaid Program. Beginning October 1, 1982, it began implementation of a 3-year demonstration project under which a specified set of services will be provided to the indigent on a prepaid basis.

States may also cover additional persons as categorically needy; these include persons receiving State supplement SSI payments (SSP) or persons who would be eligible for cash assistance except that they are residents in medical institutions (such as skilled nursing facilities).

States must extend Medicaid eligibility to aged, blind, and disabled persons who were eligible for Medicaid in December 1973 as long as they meet the 1973 criteria; persons receiving mandatory State supplementary payments; persons who would be eligible for cash aid except for a State barrier disallowed by Medicaid law; and persons actually receiving SSI and/or SSP payments who lose their eligibility for SSI or SSP solely because of a cost-of-living social security increase provided they would otherwise still be eligible for such aid. Medicaid coverage must also be extended for 4 additional months to certain families whose AFDC cash assistance has been terminated provided they had received AFDC for at least 3 of the preceding 6 months; this extension applies to families whose AFDC coverage has been terminated due to increased income from or hours of employment.

Automatic Medicaid coverage for poor families is generally linked to the receipt of AFDC cash assistance, thereby restricting coverage for certain persons. This occurs in part because AFDC assistance is available only to families where one parent is absent, incapacitated, or in certain States, unemployed. To receive AFDC, a family must also meet a cash assistance standard established by each State.

Despite these restrictions, the law requires States to cover specified groups of persons even though they are not actually receiving cash payments under the AFDC program. Effective October 1, 1984, States are required to provide coverage to the following groups of persons meeting AFDC income and resources requirements:

—First time pregnant women from the time of medical verification of pregnancy;

—Pregnant women in two-parent families where the principal breadwinner is unemployed, from the medical verification of pregnancy; and

—All children born on or after October 1, 1983, up to age 5.

States are also required to extend Medicaid coverage to families who lose their eligibility for AFDC and therefore Medicaid because the disregard provision of the AFDC program can no longer be applied to them. This AFDC provision requires States, for purposes of calculating AFDC benefits during the first few months of a job, to disregard one-third of monthly earnings that remain after deduction of the first $30 in monthly earnings, a standard allowance, and child care costs up to a specified level. States are now required to provide 9 months of Medicaid coverage (and may at their option extend coverage for an additional 6 months) to families who lose their AFDC eligibility because of the expiration of the disregard. Families who lost eligibility prior to October 1, 1984, are also eligible for Medicaid for the same time period, provided:

—They disclose any private health insurance coverage at the time of application;

—They apply within 6 months froom the date the implementing regulations become final; and

—They would have been continuously eligible for AFDC if the $30 plus one-third disregard had been applied.

States may also extend coverage to additional population groups. A State may extend coverage to two-parent families where one parent is employed (even if such families are ineligible for AFDC in the State). States are required to extend coverage to all children under age 5 born on or after October 1, 1983, provided they meet the AFDC cash assistance standards. States may also cover all or specified categories of children under age 18 (or, at State option, age 21), providing they meet the AFDC cash assistance standards. For example, States may cover children in foster care or subsidized adoptions.

MEDICALLY NEEDY

States may also cover the medically needy under their Medicaid programs. These are persons whose income is slightly in excess of the standards for cash assistance, provided that: (1) they are aged, blind, disabled, or members of families with dependent children, and (2) their income (after deducting incurred medical expenses) falls below the State standard. As of December 1, 1984, 36 States and jurisdictions provided medically needy coverage. These States are:

Arkansas
California
Connecticut
Washington, D.C.
Guam
Hawaii
Illinois
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Montana
Nebraska
New Hampshire
New York
North Carolina
North Dakota
Northern Mariana Islands
Oklahoma
Oregon (limited program)
Pennsylvania
Puerto Rico
Rhode Island
South Carolina (limited program)
Tennessee
Utah
Vermont
Virgin Islands
Virginia
Washington
West Virginia
Wisconsin

Prior to enactment of Public Law 97-35, States having medically needy programs were required to offer comparable coverage to all four groups (that is, aged, blind, disabled, and members of families with children). Public Law 97-35 provides that, if a State offers medically needy coverage to any group, it must at a minimum provide ambulatory services to children and prenatal and delivery services for pregnant women.

MEDICARE-MEDICAID RELATIONSHIP

About 12 percent of aged and disabled Medicare enrollees are also covered by State Medicaid programs. While coverage under Medicare part A (hospital insurance) is automatic for most aged and certain disabled having insured status under the Social Security system, coverage under Medicare part B (supplementary medical insurance) requires the payment of a monthly premium. Most States make this payment for their Medicaid eligibles under a buy-in agreement. While States may buy-in to Medicare for both their cash-assistance and medically needy populations who are eligible for Medicare, Federal matching for premium payments is only available for the cash assistance group. If a State does not buy-in to part B coverage, it cannot receive Federal matching payments for services that would have been covered under Medicare if there had been a buy-in arrangement. Three States and two jurisdictions do not currently have a buy-in arrangement. These are: Louisiana, Oregon, Wyoming, Puerto Rico, and Northern Mariana Islands.

Medicaid basically supplements Medicare for persons who are dually eligible. Medicare makes the primary payment while State Medicaid expenditures are limited to payments for deductibles, coinsurance, and services not covered by Medicare.

SERVICES

States are required to offer the following services to categorically needy recipients under their Medicaid programs: inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing facility (SNF) services for those over age 21; home health services for those entitled to SNF care; early and periodic screening, diagnosis, and treatment (EPSDT) for those under age 21; family planning services and supplies; and physicians' services. They may also provide additional medical services such as drugs, intermediate care facility (ICF) services, eyeglasses, inpatient psychiatric care for individuals under age 21 or over 65. States are permitted to establish limitations on the amount of care provided under a service category (such as limiting the number of days of covered hospital care or number of physicians' visits).

Federal law establishes the following requirements for coverage of the medically needy: (1) if a State provides medically needy coverage to any group it must provide ambulatory services to children and prenatal and delivery services for pregnant women; (2) if a State provides institutional services for any medically needy group it must also provide ambulatory services for this population group; and (3) if the State provides medically needy coverage for persons in intermediate care facilities for the mentally retarded (ICF/MRs), it must offer to all groups covered in its medically needy program the same mix of institutional and noninstitutional services as required under prior law (that is, either all of the mandatory services or alternatively the care and services listed in 7 of the 17 paragraphs in the law defining covered services).

FINANCING

The Federal Government helps States share in the cost of Medicaid services by means of a variable matching formula which is periodically adjusted. The matching rate, which is inversely related to a State's per capita income, can range from 50 percent to 83 percent though currently the highest rate is 77.63 percent. Federal matching for the territories is set at 50 percent with a maximum dollar limit placed on the amount each territory can receive. The Federal share of administrative costs is 50 percent for all States except for certain items where the authorized rate is higher.

Public Law 97-35 provided that the amount of Federal matching payments to which a State was otherwise entitled was to be reduced by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. A State could lower the amount of its reduction by 1 percentage point for each of the following: (1)

operating a qualified hospital cost review program; (2) sustaining an unemployment rate exceeding 150 percent of the national average; and (3) demonstrating recoveries from fraud and abuse activities (and with respect to fiscal year 1982, third-party recoveries) equal to 1 percent of Federal payments. A State was entitled to a dollar-for-dollar offset in its reductions if total Federal Medicaid expenditures in a year fell below a specified target amount. In no case could the amount recovered exceed the total amount of reductions.

REIMBURSEMENT POLICY

States have considerable leeway in setting reimbursement levels for services. They are required to reimburse hospitals, skilled nursing facilities, and intermediate care facilities at rates that are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities in order to meet applicable laws and quality and safety standards. In developing their payment rates for hospitals, States are required to take into account the situation of facilities which serve a disproportionate number of low-income patients. Further, hospital payment rates must be sufficient to assure that Medicaid patients have reasonable access to services of adequate quality.

Practitioners and providers are required to accept payments under the program as payment in full for covered services except where nominal cost-sharing charges may be required. States may generally impose such charges with certain exceptions. They are precluded from imposing such charges on services for children under 18, services related to pregnancy, family planning or emergency services, HMO services for the categorically needy, and services provided to SNF or ICF inpatients who are required to spend all of their income for medical care except for a personal needs allowance.

ADMINISTRATION

Medicaid is a State-administered program. At the Federal level, the Health Care Financing Administration (HCFA) of the Department of Health and Human Services is responsible for overseeing State operations.

Federal law requires that a single State agency be charged with administration of the Medicaid program. Generally, that agency is either the State welfare agency, the State health agency, or the umbrella human resources agency. The single State agency may contract with other State entities to conduct some program functions. Further, States may process claims for reimbursement themselves or contract with fiscal agents or health insuring agencies to process these claims.

PROGRAM DATA

Federal Medicaid outlays are estimated (in the absence of legislative changes) at $23.0 billion in fiscal year 1985, a 14.4 percent increase over the $20.1 billion estimated for fiscal year 1984. Some of the increase in Federal spending is attributable to the discontinuance of the temporary reductions in Federal payments applicable over the fiscal year 1982–84 period.

The primary factor contributing to program increases has been inflation, particularly inflation in medical care prices. However, in recent years States have taken significant steps to slow program growth. Of particular importance are new State initiatives and experimentation in the organization, financing, and reimbursement of services.

TABLE 1.—HISTORY OF MEDICAID PROGRAM COSTS

Fiscal year	Total		Federal		State	
	Dollars (in millions)	Percent increase	Dollars (in million)	Percent increase	Dollars (in millions)	Percent increase
1966 [1]	$1,658	....	$789	....	$869	....
1967 [1]	2,368	42.9	1,209	53.2	1,159	33.5
1968 [1]	3,659	55.6	1,837	51.9	1,849	59.5
1969 [1]	4,166	13.0	2,276	23.9	1,890	2.2
1970 [1]	4,852	16.5	2,617	15.0	2,235	18.3
1971	6,176	27.3	3,374	28.9	2,802	25.3
1972 [2]	8,434	36.6	4,361	29.2	4,074	45.4
1973	9,111	8.0	4,998	14.6	4,113	1.0
1974	10,229	12.3	5,833	16.7	4,396	6.9
1975	12,637	23.5	7,060	21.0	5,578	26.9
1976	14,644	15.9	8,312	17.7	6,332	13.5
TQ [3]	4,106	NA	2,354	NA	1,752	NA
1977	17,103	[4] 16.8	9,713	[4] 16.9	7,389	[4] 16.7
1978	18,949	10.8	10.680	10.0	8,269	11.9
1979	21,755	14.8	12,267	14.9	9,489	14.8
1980	25,781	18.5	14,550	18.6	11,231	18.4
1981	30,377	17.8	17,074	17.3	13,303	18.4
1982	32,446	6.8	17,514	2.6	14,931	12.2
1983	34,956	7.7	18,985	8.4	15,971	7.0
1984 (current law estimate)	37,631	7.7	20,094	5.8	17,537	9.8

1985 (current law estimate) [5]	42,392	12.7	[6] 22,994	14.4	[6] 19,398	10.6
1986 (current law estimate)	45,982	8.5	24,742	7.6	21,240	9.5

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[1] Includes related programs which are not separately identified though for each successive year a larger portion of the total represents Medicaid expenditures. As of Jan. 1, 1970, Federal matching was only available under Medicaid.

[2] Intermediate care facilities (ICFs) transferred from the cash assistance programs to Medicaid effective January 1, 1972; data for prior periods do not include these costs.

[3] Transitional quarter (beginning of Federal fiscal year moved from July 1 to Oct. 1).

[4] Represents increase over fiscal year 1976, i.e., five calendar quarters.

[5] Includes transfer of function of State fraud control units to Medicaid from Office of Inspector General.

[6] Temporary reductions in Federal payments authorized for fiscal years 1982–84 will be discontinued in fiscal year 1985.

Note: Totals may not add due to rounding.

Sources: "Budget of the U.S. Government" fiscal years 1969–85, and conversations with officials of Health Care Financing Administration.

TABLE 2.—UNDUPLICATED NUMBER OF MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY, FISCAL YEARS 1972–83

[Number in thousands]

Fiscal year	Total	Aged 65 or over	Blindness	Permanent and total disability	Dependent children under age 21	Adults in families with dependent children	Other [1]
Ending June:							
1972	17,606	3,318	108	1,625	7,841	3,137	1,576
1973	19,622	3,496	101	1,804	8,659	4,066	1,495
1974	21,462	3,732	135	2,222	9,478	4,392	1,502
1975	22,007	3,615	109	2,355	9,598	4,529	1,800
1976	22,815	3,612	97	2,572	9,924	4,774	1,836
Ending September:							
1977 [2]	22,831	3,636	92	2,710	9,651	4,785	1,959
1978	21,965	3,376	82	2,636	9,376	4,643	1,852
1979	21,520	3,364	79	2,674	9,106	4,570	1,727
1980	[3] 21,605	3,440	92	2,819	9,333	4,877	1,499
1981	[3] 21,980	3,367	86	2,993	9,581	5,187	1,364
1982	[3] 21,603	3,240	84	2,806	9,563	5,356	1,434
1983	[3] 21,494	3,247	76	2,956	9,418	5,467	1,325
1984 [3]	21,915	3,097	74	2,865	9,221	5,347	1,311
1985 (current law estimate) [3]	22,147	3,123	75	2,921	9,285	5,381	1,362
1986 (current law estimate) [3]	22,524	3,152	77	2,979	9,388	5,449	1,479

[1] This category is composed predominantly of children not meeting the definition of "dependent" children, i.e., "Ribicoff children."

[2] Fiscal year 1977 began in October 1976 and was the first year of the new Federal fiscal cycle. Before 1977, the fiscal year began in July.

[3] Beginning in fiscal year 1980, recipients' categories do not add to the unduplicated total due to the small number of recipients that are in more than one category during the year.

Sources: Social Security Bulletin, Annual Statistical Supplement, 1983, SSA Publication No. 13-11700. Fiscal years 1984–86 data from HCFA, unpublished tables.

TABLE 3.—TOTAL AND PER CAPITA MEDICAID PAYMENTS FOR CATEGORICALLY NEEDY AND MEDICALLY NEEDY, PRELIMINARY ESTIMATES, FISCAL YEAR 1983

	Amount (in millions)	Percent	Per capita amount
Categorically needy:			
Receiving cash payments	$17,089.1	52.8	$1,059
Aged	3,003.9	9.3	1,686
Blind	132.6	0.4	2,004
Disabled	6,863.7	21.2	3,176
Children in AFDC families	3,243.1	10.0	409
Adults in AFDC families	3,845.8	11.9	884
Not receiving cash payments	6,400.0	19.8	3,437
Aged	4,034.0	12.5	5,971
Blind	20.8	0.1	4,103
Disabled	1,837.3	5.7	6,924
Children in AFDC families	179.3	0.6	363
Adults in AFDC families	166.7	0.5	529
Other title XIX recipients	161.8	0.5	954
Total, categorically needy	23,489.1	72.6	NA
Medically needy:			
Aged	4,915.9	15.2	6,227
Blind	29.6	0.1	5,959
Disabled	2,482.1	7.7	7,005
Children in AFDC families	399.7	1.2	569
Adults in AFDC families	470.6	1.5	906
Other title XIX recipients	563.5	1.7	1,064
Total, medically needy	8,861.4	27.4	3,154
Total	32,350.5	100.0	1,617

Note: Totals may not add due to rounding. The per capita is based on data which exclude the territories.

NA—Not available.

Source: Health Care Financing Administration (HCFA), DHHS, unpublished tables.

TABLE 4.—MEDICAID RECIPIENTS AND PAYMENTS BY BASIS OF ELIGIBILITY, PRELIMINARY ESTIMATES, FISCAL YEAR 1983

	Amount (in millions)	Percent of total	Recipients (in thousands)	Percent of total	Per capita payment
Aged	$11,953.9	37.0	3,249	14.5	$3,681
Blind	183.1	0.6	76	0.3	2,401
Disabled	11,183.1	34.6	2,952	13.1	3,784
Dependent children under 21	3,822.1	11.8	9,412	41.9	406
Adults in families with dependent children	4,483.1	13.9	5,456	24.3	820
Other	725.3	2.2	1,323	5.9	547
Total	32,350.5	100.0	[1] 21,471	[2] 100.0	1,505

[1] Total is unduplicated count of recipients. A small number of recipients are in more than one category during the year.

[2] The percent of recipients in based upon the unduplicated count.

Note: Totals may not add due to rounding. Based on data which include the territories.

Source: HCFA, unpublished tables.

TABLE 5.—MEDICAID PAYMENTS BY SERVICE CATEGORY, FISCAL YEAR 1983

	Amount (in millions)	Percent
Inpatient hospital	$9,734.6	30.1
General	(8,802.0)	(27.2)
Mental [1]	(932.6)	(2.9)
Skilled nursing facilities	4,621.0	14.3
Intermediate care facilities [1]	9,459.4	29.2
Facilities for mentally retarded [1]	(4,078.8)	(12.6)
Other [1]	(5,380.6)	(16.6)
Physician	2,174.6	6.7
Dental [1]	467.1	1.4
Other practitioner [1]	226.2	0.7
Outpatient hospital	1,544.9	4.8
Clinic [1]	478.9	1.5
Lab and X-ray	183.8	0.6
Home health	597.2	1.8
Prescribed drugs [1]	1,771.2	5.5
Family planning	156.0	0.5
Early and periodic screening	115.7	0.4
Rural health clinic	5.5	([3])
Other [2]	814.5	2.5
Total	32,350.5	100.0

[1] Optional services.

[2] Predominantly optional services.

[3] Less than 0.1.

Note: Totals may not add due to rounding. Based on data which include the territories.

Source: HCFA, unpublished tables.

TABLE 6.—AVERAGE EXPENDITURE PER RECIPIENT FOR CATEGORICALLY NEEDY PERSONS WHO ARE ALSO RECEIVING AN SSI OR AFDC PAYMENT, BY BASIS OF ELIGIBILITY, BY STATE, PRELIMINARY ESTIMATES, FISCAL YEAR 1983

[In dollars]

State	Total	SSI aged	SSI blind	SSI disabled	AFDC child	AFDC adult
United States	1,059	1,686	2,003	3,176	409	884
Alabama	844	844	1,279	1,784	342	778
Alaska	2,283	6,575	2,398	6,406	616	1,062
Arkansas	1,197	1,260	2,203	2,523	378	844
California	845	834	1,471	2,220	344	757
Colorado	1,521	2,679	14,621	6,684	356	770
Connecticut	782	1,466	2,838	2,739	474	999
Delaware	982	2,316	1,486	3,379	407	815
District of Columbia	1,540	5,424	3,594	5,034	478	1,137
Florida	904	1,209	1,557	2,300	317	700
Georgia	1,078	1,175	1,719	2,402	396	1,029
Hawaii	835	1,880	2,031	3,757	390	880
Idaho	574	650	422	1,338	363	814
Illinois	841	1,807	1,919	3,088	399	836
Indiana	1,227	3,819	3,093	5,587	472	1,248
Iowa	1,110	1,689	1,458	4,396	474	957
Kansas	1,204	2,305	3,199	5,150	482	1,028
Kentucky	847	964	1,481	2,012	297	772
Louisiana	1,338	1,476	2,336	3,676	397	924
Maine	963	1,490	1,824	2,654	361	896

TABLE 6.—AVERAGE EXPENDITURE PER RECIPIENT FOR CATEGORICALLY NEEDY PERSONS WHO ARE ALSO RECEIVING AN SSI OR AFDC PAYMENT, BY BASIS OF ELIGIBILITY, BY STATE, PRELIMINARY ESTIMATES, FISCAL YEAR 1983—Continued

[In dollars]

State	Total	SSI aged	SSI blind	SSI disabled	AFDC child	AFDC adult
Maryland	954	2,258	1,955	2,368	486	1,017
Massachusetts	1,394	1,903	....	3,903	568	1,065
Michigan	819	1,971	2,309	3,491	351	947
Minnesota	1,440	4,235	5,526	9,005	410	834
Mississippi	736	903	1,164	1,487	323	755
Missouri	640	996	1,200	1,369	427	763
Montana	1,112	2,049	2,633	3,002	374	1,075
Nebraska	1,218	2,952	4,210	4,127	474	864
Nevada	1,946	1,480	2,448	6,861	644	1,271
New Hampshire	655	625	1,105	2,202	276	512
New Jersey	1,002	2,525	2,191	3,375	416	935
New Mexico	983	974	2,842	2,481	368	932
New York	1,698	3,778	5,468	5,026	574	1,045
North Carolina	943	1,399	2,042	2,763	369	756
North Dakota	1,534	3,422	1,791	4,237	627	1,106
Ohio	1,074	2,932	2,596	4,243	488	1,096
Oklahoma	859	1,701	1,828	2,474	249	475
Oregon	818	2,375	2,154	2,573	316	867
Pennsylvania	942	2,605	1,572	3,359	311	644
Rhode Island	987	2,614	1,419	3,299	311	660

South Carolina	742	914	996	1,626	214	694
South Dakota	1,492	2,085	1,841	4,727	470	877
Tennessee	1,097	1,049	1,676	2,122	555	981
Texas	1,384	1,488	2,121	3,816	428	1,178
Utah	1,211	1,546	1,525	5,383	385	972
Vermont	1,173	1,765	1,539	4,401	354	684
Virginia	1,104	2,025	1,800	3,222	332	812
Washington	1,142	4,933	4,934	14,260	403	835
West Virginia	553	972	1,057	1,140	242	543
Wisconsin	1,141	1,846	4,918	4,512	489	941
Wyoming	979	1,969	1,187	3,564	433	944

Source: HCFA, DHHS, unpublished tables.

IV. DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF THE AGED

This section presents selected data on the demographic and economic characteristics of the elderly. The data presented here typically covers several time periods and describes the number (table 1), marital status (table 2), living arrangements (table 3), labor force participation (tables 4), poverty status (table 5), income (tables 6-12), and assets (tables 13 and 14) of the elderly, and table 15 presents major demographic projections used in forecasting social security costs. The tables are derived from the following sources:

(1) Special tabulations of the March 1984 CPS survey by the Congressional Research Service;

(2) U.S. Bureau of the Census, Current Population Report, series P-20, P-60, and P-23;

(3) Social Security Administration, Survey of Income and Program Participation, 1979; and

(4) 1981 Employment and Training Report of the President.

The data source for each table is noted at the bottom of each table.

Some definitions that may be useful for reading the tables:

(1) Aged and elderly refer to anyone 65 years and older.

(2) OASDI and social security are interchangeable terms.

(3) Supplemental security income, at times, is abbreviated SSI.

Table 1 illustrates that the elderly as a percentage of the population will increase from 6.8 percent in 1940 to 13.0 percent in the year 2000. The actual number of individuals 65 and over will almost quadruple from 9 million in 1940 to 36.2 million in the year 2000. In addition, the percentage of the population age 75 and over, particularly women, will grow at an even faster rate. For example, the percentage of the population that is female and over age 75 was 1.1 percent in 1940 and will climb to 4.2 percent by the year 2000. In actual numbers, this is an increase from 1.4 million to 11.7 million.

Table 2 presents information on the marital status of aged individuals over time. The significant feature of the table is the large percentage of women 75 years and older who are widowed. As shown in table 3, 67.5 percent of widowed women age 65 and older lived alone in 1984. Compared to 1970, the number of widowed women living alone has increased from 3.3 million to 5.3 million.

Table 4 presents information on the labor force participation rates of individuals age 55 and older. Since 1950, the labor force participation of men in this age group has steadily declined. For example, the rate has gone from 86.9 percent for men age 55 to 64 to 68.5 percent in 1984. The rate for men 65 and older has declined from 45.8 percent to 16.3 percent. The labor force participation rates for women are significantly different. The labor force participation for women age 55 to 64 has increased from 27.0 percent in 1950 to 41.7 percent in 1984. The rate for women 65 and over has decreased only slightly.

TABLE 1.—ELDERLY POPULATION AS PERCENT OF TOTAL POPULATION AND DISTRIBUTION OF ELDERLY BY AGE, 1940 TO 1970, AND PROJECTION 1979 TO 2025, SELECTED YEARS

	1940	1950	1960	1970	1980	1990[1]	2000[1]	2025[1]
Population 65 years and older (in thousands)	9,019	12,257	16,207	20,101	26,364	32,570	36,184	60,768
Percent of total population	6.8	8.2	9.0	9.9	11.2	12.6	13.0	19.3
Certain age and sex groupings as a percent of the population 65 years and older:								
Total 65 years and older	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Men 65 and older	48.8	46.8	45.1	42.0	40.1	39.7	39.7	42.4
Men 65 to 74	35.1	32.7	31.0	27.0	26.0	24.9	22.7	26.3
Men 75 and older	13.7	14.1	14.1	15.0	14.1	14.8	17.0	16.1
Women 65 and older	51.2	53.2	54.9	58.0	59.9	60.3	60.3	57.6
Women 65 to 74	35.6	35.9	35.9	34.8	33.8	32.0	27.9	30.3
Women 75 and older	15.6	17.3	19.0	23.2	26.1	28.3	32.4	27.3

[1] Projection.

Note: Population data for 1940 and 1950 include coterminous U.S. only; 1960 and 1970 refer to total U.S. population; 1980 to 2025 refer to total U.S. plus the outlying areas and include an adjustment for the population under count.

Source: 1940 to 1970, U.S. Bureau of the Census, U.S. Census of Population, 1940, 1960, and 1970; 1980 to 2025, 1984 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, and unpublished estimates from the Office of the Actuary, Social Security Administration.

TABLE 2.—MARITAL STATUS OF AGED INDIVIDUALS,[1] BY SEX AND AGE, 1968, 1978, AND 1984

	1968		1978		1984	
	65 to 74	75 and over	65 to 74	75 and over	65 to 74	75 and over
Men:						
Number (in thousands)	5,096	2,776	6,080	3,090	7,067	3,682
Percent	100.0	100.0	100.0	100.0	100.0	100.00
Married, wife present	79.4	59.7	78.1	68.2	80.0	67.3
Married, wife absent	2.0	2.3	3.0	2.1	1.9	2.8
Widowed	10.8	30.3	9.7	23.0	8.9	23.8
Divorced	2.6	1.9	3.5	1.8	3.7	2.0
Never married	5.3	5.8	5.7	4.8	5.5	4.0
Women:						
Number (in thousands)	6,395	3,978	8,189	5,109	9,172	6,370
Percent	100.0	100.0	100.0	100.0	100.00	100.00
Married, husband present	45.6	20.5	46.2	21.6	48.8	22.9
Married, husband absent	1.5	.8	2.2	1.3	1.9	1.0
Widowed	43.3	70.2	41.2	69.3	39.1	66.9
Divorced	2.5	1.4	3.9	2.1	5.2	2.7
Never married	7.1	7.2	6.6	5.7	5.0	6.5

[1] Civilian noninstitutional population only.

Note: Details may not add to totals due to rounding.

Source: U.S. Bureau of the Census, Current Population Report, series P–20, Nos. 187, 338, and 372, and unpublished data.

TABLE 3.—LIVING ARRANGEMENTS OF PERSONS AGED 65 AND OVER, 1970 AND 1984

[Civilian noninstitutionalized population, number in thousands]

Living arrangement	Total	Percent	Widowed men	Percent	Widowed women	Percent
Total:						
1970	19,061	100.0	1,333	100.0	5,946	100.0
1984	26,291	100.0	1,510	100.0	7,847	100.0
In families:						
1970	13,347	70.0	499	37.4	2,386	40.1
1984	17,676	67.2	441	29.2	2,323	29.6
Living alone:						
1970	5,071	26.6	708	53.1	3,309	55.7
1984	7,966	30.3	953	63.1	5,298	67.5
Other:						
1970	645	3.4	126	9.5	251	4.2
1984	649	2.5	116	7.7	226	2.9

Source: Bureau of the Census, Current Population Reports, P–20, No. 376 and unpublished data.

TABLE 4.—CIVILIAN LABOR FORCE PARTICIPATION RATES[1] OF PERSONS 55 YEARS AND OVER, BY AGE AND SEX, SELECTED YEARS, 1950–84

Years	1950	1955	1960	1965	1970	1975	1980	1984
Men:								
55 to 64	86.9	87.9	86.8	84.6	83.0	75.8	72.3	68.5
55 to 59	(2)	92.5	91.6	90.2	89.5	84.4	81.9	80.2
60 to 64	(2)	82.5	81.1	78.0	75.0	65.7	61.0	56.1
60 to 61	(2)	(2)	(2)	84.8	82.6	75.2	71.8	(2)
62 to 64	(2)	(2)	(2)	73.2	69.4	58.8	52.8	(2)
65 and over	45.8	39.6	33.1	27.9	26.8	21.7	19.1	16.3
Women:								
55 to 64	27.0	32.5	37.2	41.4	43.0	41.0	41.5	41.7
55 to 59	(2)	35.6	42.2	47.1	50.4	47.9	48.6	49.8
60 to 64	(2)	29.0	31.4	34.0	36.1	33.3	33.3	33.4
60 to 61	(2)	(2)	(2)	40.4	41.4	39.5	39.8	(2)
62 to 64	(2)	(2)	(2)	29.5	32.3	29.0	28.6	(2)
65 and over	9.7	10.6	10.8	10.0	9.7	8.3	8.1	7.5

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[1] Civilian labor force as percent of civilian population.

[2] Data not available.

Source: Monthly Labor Review, November 1979, 1981 Employment and Training Report of the President, and January issue of Employment and Earnings.

Table 5 presents information on the poverty status of elderly individuals. Overall, 3.7 million, or 14.1 percent of the noninstitutionalized aged, were poor in 1983. In spite of the slightly lower incidence of poverty among the aged than for the population as a whole, poverty among the aged varied considerably. As with other groups, the poverty rate among the black aged was higher than that of the white aged—36.3 percent compared to 12.0 percent, respectively. Unrelated aged individuals, who generally tend to be older than aged persons living in families and are likely to be female, had a poverty rate (26.5 percent), over three times greater than that of aged persons living in families (8.1 percent). White unrelated individuals had a poverty rate of 23.3, while black unrelated individuals had a rate of 58.2 percent. Women, who accounted for 59.1 percent of the noninstitutionalized aged population, accounted for 71.1 percent of the aged poor.

TABLE 5.—CHANGES IN POVERTY STATUS OF ALL PERSONS, AND THE ELDERLY BY SEX, RACE AND FAMILY STATUS, SELECTED YEARS 1959 TO 1983

[Percent below the poverty level]

	1959	1966	1970	1975	1980	1982	1983 [2]
All persons	22.4	14.7	12.6	12.3	13.0	15.0	15.2
Persons 65 years old and over:							
Both sexes	35.2	28.5	24.5	15.3	15.7	14.6	14.1
Men	N.A.	23.7	19.0	11.4	10.9	10.4	10.0
Women	N.A.	32.1	28.4	18.1	19.0	17.5	17.0
Black women [1]	N.A.	57.3	53.2	40.2	42.6	42.4	41.7
Wives	57.7	51.9	41.8	23.8	23.5	N.A.	N.A.
Unrelated individual	84.6	83.9	79.2	65.8	66.6	66.3	63.6
Black men [1]	N.A.	52.2	41.3	31.0	31.5	31.8	28.3
Family head	60.4	50.0	39.2	26.0	25.0	N.A.	N.A.
Unrelated individual	77.5	72.7	59.7	51.8	45.4	50.2	46.0
White women [1]	N.A.	30.3	26.5	16.1	16.8	15.1	14.7
Wives	28.9	20.2	14.0	7.2	7.0	N.A.	N.A.
Unrelated individual	61.8	55.2	47.5	29.1	29.3	25.4	24.5
White men [1]	N.A.	21.3	17.0	9.5	9.0	8.3	8.2
Family head	26.8	18.7	13.8	7.1	6.9	N.A.	N.A.
Unrelated individual	56.8	41.3	36.0	23.8	21.1	16.9	18.5

[1] Total includes other types of family members not separately designated.

[2] The poverty definition used to produce the estimates for 1981 and years after changed slightly from previous years. If the new method were used for 1980, the heading "All persons" would read 13.2 percent below the poverty level, not 13.0 percent.

N.A.—Not available.

Sources: U.S. Bureau of the Census, Current Population Reports series P-60 referring to the population below the poverty level, various years in series.

Tables 6 and 7 present data for aged individuals living in families. In parallel fashion, tables 8 and 9 present information for individuals living alone (technically unrelated individuals). Table 6 presents the percentage of aged families (unrelated individuals) classified on the basis of total income to the poverty threshold with income from various sources. For example, from table 6 we learn that 15.2 percent of families with income under 50 percent of the poverty threshold had income from earnings. Poor (the second to last column in table 6) is defined in all of these tables as having income less than the poverty threshold. Nonpoor are all families (unrelated individuals) with incomes above the poverty threshold.

Table 7 presents the percent of total income which is comprised of various types of income where families (unrelated individuals) are again classified on the basis of total income to the poverty threshold. For example, from table 7 we learn that 10.2 percent of total family income for poor families is comprised of earnings as compared to 36.9 percent for nonpoor families. Pension income accounts for 2.6 percent of total income received by poor families while it comprises 12.8 percent for nonpoor families.

Elderly individuals living alone are more than three times as likely to be living in poverty (26.5) as compared to aged individuals living in families (8.7). The percentage of single elderly below 1.25 percent of the poverty threshold is 41.1 percent. This compares to 14.2 for families with an elderly member and to 13.4 percent for families without an elderly member.

Overall, about half of all families with an aged member had earnings (table 6). About 92 percent also received social security. Consequently, at least 40 percent of all families with an aged member received both retirement and earned income during the year. In some cases, these families may consist of an older retiree, typically a male, with a younger spouse who may still be working. In other cases, a single aged person may live with children or relatives who are actively involved in the labor force.

Nonpoor families with an aged member were more likely to have income from earnings than were poor families—50 percent compared to 23 percent, respectively.

Retirement income in the form of social security and pensions differed markedly between the poor and nonpoor. Receipt of social security was somewhat higher for nonpoor (93 percent) than for poor (83 percent) families with an aged member.

Pension income was considerably higher among nonpoor than poor aged. Approximately 47 percent of the nonpoor aged in families received pension income, compared to 6 percent of the poor. Since retirement income is linked to prior work experience and earnings, it is likely that most nonpoor aged had higher earnings when they worked than those that are poor.

Income from savings and investments, in the form of interest and dividends, was a significant part of the nonpoor aged families' total income, accounting for 19 cents out of every dollar received.[1] About 79 percent of these families reported income in the form of interest and dividends.

In comparison to the nonpoor, poor families with an aged member relied mainly upon social security and cash public assistance, presumably SSI, for income support. About 29 percent of these poor families received cash public assistance. Among this group, an average of 66 cents out of every dollar came from social security, and 14 cents from cash public assistance. Nearly one-third of these families received food stamps, which on average, added an additional 9 cents to every dollar of income received.

The pattern of income receipt among aged unrelated individuals was, with few exceptions, very similar to that of aged persons in families. Only about 16 percent of nonpoor aged and 5 percent of poor aged unrelated individuals reported income from earnings. Income from interest and dividends was even more important for the nonpoor, accounting for 31 percent of their total income, on average, compared to 4 percent for the poor.

Among poor aged unrelated individuals, the contribution of food stamps to total income was much smaller (about 2 cents for each dollar of cash income) than that of the aged poor living in families (about 9 cents out of each dollar of cash income).

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[1] Withdrawals from savings are not included as income on the CPS. For the aged in particular, dissaving may provide an important means of maintaining a desired level of consumption.

TABLE 6.—PERCENT OF FAMILIES WITH ANY MEMBER AGE 65 OR OVER WITH INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] 1983

	Ratio of total income to poverty threshold								Poor	Nonpoor
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over		
Number of families (in thousands)	(214)	(270)	(479)	(585)	(699)	(1,526)	(2,553)	(4,824)	(964)	(10,188)
Percent of families	1.9	2.4	4.3	5.2	6.3	13.7	22.9	43.3	8.6	91.4
Earnings	15.2	27.3	23.5	30.1	29.2	30.6	48.8	62.9	22.7	50.3
OASDI, railroad retirement	61.7	83.3	92.8	91.6	96.5	94.8	95.5	90.2	83.2	92.8
Pensions	7.3	5.9	5.9	10.3	20.8	35.7	51.1	55.9	6.2	46.6
Unemployment compensation, workers compensation, veterans payments	7.7	9.5	8.5	13.6	12.7	12.5	12.1	10.0	8.6	11.3
AFDC, SSI, general assistance	17.8	38.3	28.7	27.4	13.9	9.7	5.9	2.5	29.0	6.6
Child support, alimony	5.9	4.7	4.8	4.4	3.9	4.9	4.8	5.2	5.0	4.9
Interest, dividends	29.0	32.2	33.7	42.4	49.4	65.6	79.2	92.7	32.3	79.4
Food stamps	26.2	36.2	29.0	17.8	10.4	3.5	2.4	.4	30.4	3.1

[1] Based on census ("Orshansky") poverty levels.

Source: March 1984 Current Population Survey (CPS). Table prepared by CRS.

TABLE 7.—PERCENT OF TOTAL FAMILY INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] FOR FAMILIES WITH ANY MEMBER AGE 65 OR OVER, 1983

	Ratio of total income to poverty threshold									
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over	Poor	Nonpoor
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Earnings	9.3	11.7	9.7	15.1	16.1	17.2	28.4	42.3	10.2	36.9
OASDI, railroad retirement	57.8	58.1	70.6	61.6	67.1	62.2	44.8	19.8	65.7	29.3
Pensions	2.2	2.7	2.6	3.7	3.8	8.2	12.2	14.0	2.6	12.8
Unemployment compensation, workers compensation, veterans payments	4.8	3.6	2.8	4.0	2.6	2.4	2.1	.8	3.2	1.2
AFDC, SSI, general assistance	16.7	18.2	10.8	10.2	4.9	2.5	.9	.2	13.5	.8
Child support, alimony	2.9	1.1	.8	.5	.6	1.0	.6	.5	1.1	.5
Interest, dividends	6.3	4.6	2.7	4.9	4.9	6.5	11.0	22.5	3.6	18.5
Food stamps [2]	(21.0)	(14.1)	(3.8)	(1.8)	(1.0)	(.3)	(.1)	(.0)	(8.5)	(.1)

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[1] Based on census ("Orshansky") poverty levels.

[2] The cash value of food stamps was not included as part of total income, either for purposes of determining poverty status, or in the base for calculating the percentage share of total income. The numbers in this row for food stamps represent the added percentage contribution to total cash income.

Source: March 1984 Current Population Survey (CPS). Table prepared by CRS.

TABLE 8.—PERCENT OF UNRELATED INDIVIDUALS AGE 65 AND OVER WITH INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] 1983

	Ratio of total income to poverty threshold								Poor	Nonpoor
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over		
Number of unrelated individuals (in thousands)	(272)	(467)	(1,509)	(1,261)	(921)	(1,191)	(1,359)	(1,551)	2,248	6,283
Percent of unrelated individuals	3.2	5.5	17.7	14.8	10.8	14.0	15.9	18.2	26.4	73.6
Earnings	9.1	5.3	4.7	4.9	7.3	13.3	21.5	26.7	5.4	15.8
OASDI, railroad retirement	52.0	89.2	91.6	95.2	96.8	97.9	95.9	88.0	86.3	94.3
Pensions	6.6	7.3	5.0	12.1	22.4	39.6	51.1	51.9	5.7	37.1
Unemployment compensation, workers compensation, veterans payments	1.5	6.8	7.3	6.5	5.7	6.7	4.9	5.2	6.5	5.8
AFDC, SSI, general assistance	9.2	23.4	36.8	14.9	4.6	1.7	.3	.5	30.6	4.2
Child support, alimony	2.0	2.1	.7	1.6	1.6	2.0	3.3	4.4	1.2	2.7
Interest, dividends	36.1	41.5	34.3	52.3	70.2	78.1	90.4	95.2	36.0	78.7
Food stamps	10.0	24.0	30.5	7.7	2.6	1.0	.3	.2	26.6	2.3

[1] Based on census ("Orshansky") poverty levels.

Source: March 1984 Current Population Survey (CPS). Table prepared by CRS.

TABLE 9.—PERCENT OF TOTAL FAMILY INCOME FROM VARIOUS SOURCES, BY THE RATIO OF TOTAL INCOME TO THE POVERTY THRESHOLD,[1] FOR FAMILIES WITH ANY MEMBER AGE 65 OR OVER, 1983

	Ratio of total income to poverty threshold									
	Under 0.50	0.50 to 0.74	0.75 to 0.99	1.00 to 1.24	1.25 to 1.49	1.50 to 1.99	2.00 to 2.99	3.00 and over	Poor	Nonpoor
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Earnings	6.2	1.2	1.4	1.2	2.8	4.8	9.3	15.4	1.5	10.6
OASDI, railroad retirement	68.9	77.8	76.5	81.2	77.2	64.2	45.8	20.4	76.4	40.8
Pensions	6.1	3.1	1.5	3.1	6.3	11.0	16.7	17.6	1.9	14.5
Unemployment compensation, workers compensation, veterans payments	.3	2.7	2.0	2.2	1.8	2.2	1.6	.7	2.0	1.3
AFDC, SSI, general assistance	5.2	10.6	15.0	6.3	1.2	.5	.1	.0	13.9	.8
Child support, alimony	.6	.5	.1	.5	.3	.4	.8	1.4	.2	1.0
Interest, dividends	12.7	4.0	3.6	5.4	10.5	16.8	25.8	44.6	4.0	31.2
Food stamps [2]	(3.2)	(2.8)	(2.0)	(.4)	(.1)	(.0)	(.0)	(.0)	(2.2)	(.1)

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[1] Based on census ("Orshansky") poverty levels.

[2] The cash value of food stamps was not included as part of total income, either for purposes of determining poverty status, or in the base for calculating the percentage share of total income. The numbers in this row for food stamps represent the added percentage contribution to total cash income.

Source: March 1984 Current Population Survey (CPS). Table prepared by CRS.

Table 10 explores the effectiveness of various income sources in addressing poverty. Families differ markedly by the combinations of income upon which they rely for support. For example, families with an aged member and aged unrelated individuals typically rely upon a combination of income from social security, pensions, returns on investments and saving, as well as earnings. In combination, these sources offer the potential for income support above the poverty threshold. However, as the sole source of income support, none of these sources may be deemed adequate.

One way of assessing the anti-poverty effectiveness of various income sources is to estimate the number of persons who would be counted as poor if a particular source of income were not received. The additional number of persons that are counted as poor provides an estimate of the number of people lifted out of poverty by a particular income source. For example, the effect of social security upon poverty can be seen by comparing the number who would be counted as poor if they did not receive social security, with the number of poor after social security income is counted (column 3 compared to column 1 of table 10).

Another way of assessing the effectiveness of various income sources upon poverty is by estimating the degree to which those sources reduce the gap between a poor family's income and the poverty threshold (bottom 3 rows of table 10). This concept is sometimes known as the "poverty gap" of the "poverty income deficit." A cash transfer program which is highly targeted on the poor may do little to eliminate poverty—that is, to reduce the number who are counted as poor—but such a program may still have a very real impact by reducing the degree of poverty as viewed in terms of the poverty gap.

Table 10 shows the relative antipoverty effect of various income sources in 1983 upon the aged. For example, the first column shows the number of elderly persons who were poor, and the poverty rate, in 1983. The second column shows how many persons would be poor if they had only earnings and miscellaneous sources of income (interest, dividends, alimony and child support) upon which to depend. Similarly, the third column shows how many persons would be counted as poor if they had all sources of income currently available to them, except for social security and railroad retirement. The relative effect of each source can be seen by comparing the number in poverty under the alternate income definitions with the first column. For purposes of illustration, the cash value of food stamps is also included, even though food stamps are not included as income under the existing official definition of poverty. The last three rows of table 10 show the aggregate poverty gap (in millions of dollars) and average poverty gap[2] per person. The aggregate poverty gap is the amount of dollars that would be required to give all persons in poverty an income equal to the poverty line.

Private and government pensions may be viewed as either deferred compensation, provided by employers, or as savings for retirement. Pension benefits are closely related to the labor market, usually being directly or indirectly related to years of service and wage and salary levels attained when individuals were working. Private and government pensions played an important role in reducing poverty among the aged. In 1983, about one-fifth of total pension benefits went to persons who were poor before they received them. These benefits reduced the incidence of poverty among the aged by about 19 percent, and reduced the aggregate poverty gap by nearly 30 percent.

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[2] The average poverty gap per person is the total family poverty gap divided by the number of family members.

Social insurance programs provide a second tier of income support, helping to protect covered individuals from loss of work related income resulting from a number of specific risks, such as old age, unemployment, and work related disabilities. Social insurance programs are second only to earnings in terms of their effect upon poverty. Among these programs, social security is the largest. In fiscal year 1983, social security outlays amounted to $172.3 billion. While only about 50 percent of social security payments [3] went to persons who were poor before they received them (the pretransfer poor), social security had the greatest impact upon reducing poverty other than earnings. Social security reduced the aggregate povery gap by nearly 90 percent for persons age 65 and over. Social security income lifted approximately 9.7 million older persons out of poverty. Social security reduced the poverty rate among the aged from 51.0 percent to 14.1 percent—a reduction of 72.3 percent.

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[3] Includes railroad retirement.

TABLE 10.—NUMBER OF PERSONS AGE 65 AND OVER IN POVERTY AND THE POVERTY GAP UNDER VARIOUS INCOME CONCEPTS, 1983

	Total income official poverty measure	Only earnings, dividends, interest, and misc. income	Total income less—				Total income plus—food stamps
			Social security, railroad retirement	Pensions	Unemployment compensation, workers compensation, veterans pension	AFDC, SSI, general assistance	
Poor persons age 65 and over (in thousands)	3,711	16,409	13,407	4,575	4,086	4,231	3,552
Poverty rate	14.1	62.4	51.0	17.4	15.5	16.1	13.5
Percentage change			−72.3	−18.9	−9.2	−12.3	−4.3
Poverty gap:							
Persons age 65 and over (in millions)	$4,117	$47,882	$35,134	$5,821	$4,945	$6,472	$3,841
Per elderly poor person [1]	$1,109	$2,918	$2,621	$1,272	$1,210	$1,530	$1,081
Percentage change			−88.3	−29.0	−16.6	−36.4	−6.7

[1] The average poverty gap per poor person is the total family poverty gap divided by the number of family members.

Table 11 represents, for families varying by age of head, aggregate family income divided by the number of persons in such families. For example, the table shows that per capita income of families with an aged head was $7,238 in 1980, slightly less than that of all families ($7,753). From 1970 to 1975 real growth in per capita income of families with an aged head was substantially greater than that of all families (11.2 percent versus 7.9 percent). However, from 1975 to 1980 per capita income of aged families rose at a slower rate than that of all families (3.7 percent versus 5.9 percent). Unrelated individuals are considered as families.

Table 12 shows the average income per household member before and after taxes for calendar year 1982. Taxes simulated in the study included Federal income taxes, State individual income taxes, property taxes on owner-occupied housing, and payroll taxes. They do not include sales or excise taxes.

As shown in the table, after-tax income of elderly individuals is exceeded only by households headed by individuals aged 55–64. The amount of taxes paid as a percent of income varied from 13.2 percent of income for household members in households headed by someone age 65 or older to 25.4 percent of income in households where the head was age 55–59. In using income per household member across different family types, it should be noted that most households headed by someone aged 65 or over are one- or two-member households and thus housing consumes a greater proportion of household income.

TABLE 11.—PER CAPITA FAMILY INCOME,[1] BY AGE OF FAMILY HEAD, FOR SELECTED YEARS

[In 1980 dollars]

Age of family head	1970	1975 (percent change: 1970 to 1975)	1980 (percent change: 1975 to 1980)	Percent change: 1970 to 1980
All families	$6,784	$7,320 (7.9)	$7,753 (5.9)	14.3
25 to 34	$6,001	$6,841 (14.0)	$7,172 (4.8)	19.5
35 to 44	$5,827	$6,416 (10.1)	$7,172 (11.8)	23.1
45 to 54	$7,803	$8,180 (4.8)	$8,584 (4.9)	10.0
55 to 64	$9,170	$9,463 (3.2)	$9,984 (5.5)	8.9
65 and over	$6,273	$6,977 (11.2)	$7,238 (3.7)	15.4

[1] Total family income divided by number of family members. Unrelated individuals are considered as families.

Source: Figures compiled by CRS from U.S. Census Bureau Reports (Series P–60).

TABLE 12.—MEAN INCOME BEFORE AND AFTER TAX PER HOUSEHOLD MEMBER, 1982

	Income per household member		Taxes per household member	Taxes as a percent of income
	Before taxes	After taxes		
Age of householder:				
15–24	6,841	5,571	1,270	18.6
25–29	8,163	6,393	1,770	21.7
30–34	8,027	6,158	1,869	23.3
35–39	8,004	6,065	1,939	24.2
40–44	8,446	6,372	2,074	24.6
45–49	9,115	6,866	2,249	24.7
50–54	10,392	7,786	2,606	25.1
55–59	11,529	8,599	2,930	25.4
60–64	10,948	8,505	2,443	22.3
65 and over	9,043	7,845	1,198	13.2
All households	8,901	6,923	1,978	22.2

Source: Estimating After-Tax Money Income Distributions Using Data From the March Current Population Survey, P–23, No. 137, table 3.

Tables 13 and 14 present information on the wealth status of elderly households. Table 13 shows that in 1979 the mean net worth (that is, wealth less unsecured debt) of households headed by an individual over 65 equalled $79,380. The largest source of the net worth of elderly households was ownership of financial assets (35 percent), followed by home equity (32 percent). Business equity, both farm and nonfarm, comprised only 7 percent of the net worth of the elderly. The mean in tables 13 and 14 include those households with zero assets.

Table 14 shows that elderly headed households had mean net worth in excess of that of any other age category, except households headed by an individual between 55 and 64. Within the category of elderly households, those headed by an individual aged 75 and over had significantly less net worth ($65,130) than those headed by an individual between 70 and 74 ($85,480) or an individual between 65 and 69 ($90,040).

TABLE 13.—PERCENTAGE COMPOSITION OF NET WORTH, MEAN AMOUNTS OF ASSETS, AND PERCENT HOLDING EACH TYPE OF ASSET, 1979

	Percentage composition	Mean amount	Percent holding asset
Age of householder 65 and over:			
Net worth [1]	100	$79,380	100
Wealth	101	79,930	99
Home equity	32	25,110	66
Financial assets	35	28,020	95
Liquid [2]	10	8,020	95
Nonliquid [3]	25	20,000	36
Business equity [4]	7	5,660	4
Other assets	18	14,090	18
Durable goods [5]	9	7,060	98
Unsecured debt [6]	1	540	39
Age of householder 75 and over:			
Net worth [1]	100	65,130	100
Wealth	101	65,530	100
Home equity	30	19,480	59
Financial assets	44	28,610	96
Liquid [2]	12	7,560	96
Nonliquid [3]	32	21,040	31
Business equity [4]	5	3,400	3
Other assets	13	8,640	16
Durable goods [5]	8	5,410	99
Unsecured debt [6]	1	400	28

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[1] Net worth is defined as wealth minus unsecured debt.

[2] Liquid financial assets include cash, checking accounts, passbook savings accounts, U.S. savings bonds.

[3] Nonliquid financial assets include bonds, CDs, stocks, mutual fund shares.

[4] Business equity: farm and nonfarm.

[5] Durable goods include equity in vehicles plus market value of household durables.

[6] Unsecured debt includes installment and noninstallment debt, unpaid medical bills, and educational loans.

Source: Daniel B. Radner. "The Wealth and Income of Aged Households," Forthcoming in the 1984 Amercian Statistical Association Proceedings, Social Statistics Section. Data developed from 1979 Income Survey Development Program file.

TABLE 14.—MEAN AND MEDIAN NET WORTH, BY AGE OF HOUSEHOLDER, 1979

	Net worth [1]	
	Mean	Median
Age of householder:		
All ages	$62,430	$25,770
Under 25	8,880	3,450
25 to 34	24,520	12,110
35 to 44	64,950	29,820
45 to 54	79,120	39,180
55 to 64	105,740	51,440
65 and over	79,380	38,720
65 to 69	90,040	47,300
70 to 74	85,480	45,440
75 and over	65,130	28,410

[1] Net worth is defined as wealth minus unsecured debt.

Source: Daniel B. Radner, "The Wealth and Income of Aged Households," Forthcoming in the 1984 American Statistical Association Proceedings, Social Statistics Section. Data developed from 1979 Income Survey Development Program File.

TABLE 15.—MAJOR LONG-TERM DEMOGRAPHIC AND LABOR FORCE PARTICIPATION ASSUMPTIONS

FERTILITY RATES

[1984 trustees' report II-B assumptions]

	1917	1933	1947	1957	1976	1981	1995	2008+
Children born per woman in her lifetime	3.33	2.17	3.18	3.68	1.74	1.85	1.93	2.00

LIFE EXPECTANCIES

[In years]

	1900	1940	1960	1980	2000	2020	2060
Male:							
At birth	46.4	61.4	66.7	69.9	73.7	74.7	76.7
Age 65	11.4	11.9	12.9	14.0	15.7	16.4	17.8
Female:							
At birth	49.0	65.7	73.2	77.5	81.1	82.3	84.5
Age 65	12.0	13.4	15.9	18.4	20.7	21.6	23.4

PERCENTAGE OF THOSE BORN WHO CAN EXPECT TO REACH AGE 65

[Using mortality for calendar year]

	1900	1940	1960	1980	2000	2020	2060
Male	37.3	55.5	63.8	70.5	78.0	79.4	81.9
Female	41.0	65.4	78.2	83.4	87.2	88.2	89.7

LABOR FORCE PARTICIPATION RATES

[Age-sex adjusted]

[In percent]

	1981	1985	1990	1995	2000+
Male	77.5	77.4	78.9	78.9	77.6
Female	52.3	55.0	58.2	59.2	59.5

COVERED WORK FORCE—NUMBER OF BENEFICIARIES AND DEPENDENCY RATIOS

	1960	1980	2000	2020	2040
Total population (in millions)	189	236	277	308	325
Covered workers	73	114	146	155	157
Beneficiaries	14	35	45	64	78
Dependency ratio [1]	.915	.756	.691	.744	.843
Worker/beneficiary ratio	5.1	3.3	3.3	2.4	2.0

[1] Ratio of nonworking to working population—population under 20 plus population over 65 divided by population 20–64.

PERCENT OF ELIGIBLE WORKERS DRAWING RETIREMENT BENEFITS

Selected ages	1981	1990	2000	2010 and later
62 to 64:				
Male	39.0	44.0	44.0	44.0
Female	51.0	53.7	54.4	[1] 54.7
65 to 69:				
Male	90.0	93.0	93.0	93.0
Female	87.5	91.1	92.3	[1] 93.0

[1] Rises very slightly after 2010.

Source: Congressional Research Service.

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